MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5000 Reg. Dist. No. 04990

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cresaptown
d. STREET ADDRESS: Box 143, Brady Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle PAUL Last AREFORD

4. DATE OF DEATH: Month May Day 12 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 13, 1917
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic, Auto
10b. KIND OF BUSINESS OR INDUSTRY: Service station
11. BIRTHPLACE (State or foreign country): Morgantown, W.Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George F. Areford
14. MOTHER'S MAIDEN NAME: Adda Sharpnack

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 217-10-1853
17. INFORMANT: Mrs. Robert P. Areford, Cresaptown, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction, left; Massive — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (b): Coronary Occlusion — -----
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Sclerosis, old; also recent thrombus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — DATE SIGNED
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D. — DEPUTY MEDICAL EXAMINER ☒ — May 12, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/15/61
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR DATE: MAY 16 '61
24b. REGISTRAR'S SIGNATURE: Carolyn L. Hess

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Item 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5001 Reg. Dist. No. 04991

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FLINTSTONE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): ROUTE 2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FLINTSTONE
d. STREET ADDRESS: ROUTE 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: FORD — Middle: ASH — Last:
4. DATE OF DEATH: Month: May XX, — Day: 17 — Year: 19 61

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: MARCH 16,1883
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARM
11. BIRTHPLACE (State or foreign country): PENNA.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ABRAM ASH
14. MOTHER'S MAIDEN NAME: MARIAN WILSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 219-34-6439
17. INFORMANT: Address: VERNA ASH ROUTE 2, FLINTSTONE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Sclerosis — ***
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: May 17, 1961
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MAY 19,1961
22c. NAME OF CEMETERY OR CREMATORY: ASH CEMETERY
22d. LOCATION (City, town, or county) (State): FLINTSTONE, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT
ADDRESS: CUMBERLAND, MD.
24a. REC'D BY REGISTRAR DATE: MAY 22 61
24b. REGISTRAR'S SIGNATURE: Cynthia L. Frame

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the ... writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to ... Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your ...
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5002

04992

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 21 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ELLERSLIE
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ROY — Middle GEORGE — Last BAGLEY

4. DATE OF DEATH: Month MAY — Day 11, — Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 25, 1897

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): BEDFORD COUNTY, PA.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: DECHARMS BAGLEY

14. MOTHER'S MAIDEN NAME: MINNIE SPIECE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO (b) Old Myocardial Infarction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerotic Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Fibrosis + Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 20 April 19 61, to 11 May, 19 61, that (I) (we) last saw the deceased alive on 10 May 19 61, and that death occured at 8:15AM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/13/61

22c. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN

22d. ADDRESS: 59 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 14, 1961

23c. NAME OF CEMETERY OR CREMATORY: Cooks Mills Cemetery

23d. LOCATION (City, town or county): Hyndman, Pa. RD#1 Bedford County

24. FUNERAL DIRECTOR'S SIGNATURE: Harvey H. Metzler

ADDRESS: Hyndman, Pa.

25a. REC'D BY REGISTRAR DATE: MAY 15 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. [illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5003 04993

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 53 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 26 Laing Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 1 26 Laing Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna; Middle: May; Last: Bird

4. DATE OF DEATH: Month: May; Day: 17; Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 23, 1882

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months; Days

IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Martinsburg, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Porterfield

14. MOTHER'S MAIDEN NAME: Sarah Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Mrs. James Bittner, Cumberland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days
422.1
DUE TO (b): Arteriosclerotic cardiovascular disease — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-19- 19 59 to 5-17- 19 61 that (I) (we) last saw the deceased alive on 5-17- 19 61 and that death occured at 4 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-19-61

22c. PHYSICIAN'S NAME (Type): G. Overton Himmelwright, M.D.

22d. ADDRESS: 133 Virginia Ave.-Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 20,1961

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest BurialPark

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: MAY 23 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5004

Reg. Dist. No. 04994

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 1 mo., 3 das.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sylvan Retreat

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaVale
d. STREET ADDRESS: 531 B Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Ellen; Last: Boch

4. DATE OF DEATH: Month: May; Day: 22; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: January 9, 1879

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry William O'Baker

14. MOTHER'S MAIDEN NAME: Elizabeth Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Francis A. Bock — Address: LaVale Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 432 Chronic progressive Dequentia — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO (b): 592 Chronic Syphilis — ?
DUE TO (c): 153 Malignant neoplasm of Rectum — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 592X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 506 Psychosis & Cerebral Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr. 19th 1961 to May 22, 1961 that I last saw the deceased alive on May 20th 1961, and that death occurred at 1:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James E. McLean M.D. — ADDRESS (Street, city or town, state): 49 Greene St. — DATE SIGNED:

PHYSICIAN'S NAME (Type): James E. McLean, M.D. — 49 Greene St., Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/25/61
22c. NAME OF CEMETERY OR CREMATORY: SS. Peter + Paul Cem.
22d. LOCATION (City, town, or county) (State): Cumberland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lowe Stein Inc. — ADDRESS: Cumb. Md.

24a. REC'D BY REGISTRAR DATE: MAY 25 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5005

CERTIFICATE OF DEATH

04995

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN: MARYLAND 40 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 202 WILMONT AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SCHILLER Middle C. Last BONIG

4. DATE OF DEATH: Month MAY Day 27 Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: MARCH 7, 1906

9. AGE (In years last birthday) 55 yrs. IF UNDER 1 YEAR Months XXX Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SUPERVISOR

10b. KIND OF BUSINESS OR INDUSTRY: TIRE CO.

11. BIRTHPLACE (County & State or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES A. BONIG

14. MOTHER'S MAIDEN NAME: ANNA M. SCHILLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) NO (If yes give war or dates of serv.)

16. SOCIAL SECURITY NO: 214 07 0015

17. INFORMANT: Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) [illegible] INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) [illegible] 17 yrs

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County)

21. **I certify** that (I) (this hospital) attended the deceased from 1956 19 to May 27, 1961, that (I) (we) last saw the deceased alive on May 27 1961, and that death occured at 1:40 PM from the causes and on the date stated above.

22a. SIGNATURE [signature] M.D.

22b. DATE SIGNED

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type) GEORGE M. SIMONS

22d. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE THEREOF MAY 29, 1961

23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK

23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.

24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT ADDRESS CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE JUN 1 '61

25b. REGISTRAR'S SIGNATURE [signature]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. The original must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5006

CERTIFICATE OF DEATH

04996

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 227 Race Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 227 Race Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma Middle: J. Last: Brant

4. DATE OF DEATH: Month: May Day: 20, Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 18, 1883

9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YR. Months: Days: IF UNDER 24 HRS. Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Ownhome

11. BIRTHPLACE (County & State, or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Rosenmarkel

14. MOTHER'S MAIDEN NAME: Barbara Bauer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Herman F. Brant

Address: 227 Race St.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
Immediate cause (a): Coronary Thrombosis
DUE TO
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last.
b: Arteriosclerosis
DUE TO
c: Old age

INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

19a. ACCIDENT WAS INDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

19b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of item 18

20c. TIME OF INJURY Hour a.m. p.m.

Month Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY Home farm factory, street, office bldg., etc.

20f. City or town County

21. I certify that (I) (this hospital) attended the deceased from June 19 61 to May 20 19 61, that (I) (we) last saw the deceased alive on May 20 19 61 and that death occured at 10:30 P.M. from the causes and on the date stated above

22a. SIGNATURE: Clay E. Durrett M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Clay E. Durrett

22d. ADDRESS: 236 Virginia Ave. Cumberland, Md.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-24-61

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City, town or county), State: Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli

ADDRESS: 108 Virginia Ave. Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: MAY 29 '61

25b REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. [illegible] be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5007

CERTIFICATE OF DEATH

04997

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

1 PLACE OF DEATH
a COUNTY: ALLEGANY
MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c LENGTH OF STAY IN 1b: 48 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: MARYLAND
b COUNTY: ALLEGANY
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 316 FAYETTE STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First LILLIAN Middle Last BROTEMARKLE
4. DATE OF DEATH: Month MAY Day 12, Yr '61

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 6-11-1874
9 AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR OR UNDER 24 HRS: Months | Days | Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Mellenger
14. MOTHER'S MAIDEN NAME: Adaline Hamill

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: None
17 INFORMANT: CHART Address: Sacred Heart Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Hypertension
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a m p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm factory, street office bldg etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from ____ 19__ to ____ 19 that (I) (we) last saw the deceased alive on 5-9 1961, and that death occurred at 12:10 P.M. from the causes and on the date stated above

22a SIGNATURE: Leo H. Ley, Jr. M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 5/13/61
22c. PHYSICIAN'S NAME (Type): Dr. Leo H. Ley, Jr., M.D.
22d ADDRESS: 456 N. Centre Street

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 13,1961
23c NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d LOCATION (City, town, or county) State: Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Byron Kight
ADDRESS: Cumberland, Md.
25a RECEIVED BY REGISTRAR DATE: MAY 17 '61
25b REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5008 04998

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Res. before admission)
a. STATE: Penn.
b. COUNTY: Clarion
c. CITY OR TOWN (If outside corporate limits write RURAL & give nearest town): Mayport
d. STREET ADDRESS: —
RESIDENCE ON A FARM? Y — NO X

3. NAME OF DECEASED (Type or print): First: Douglas; Middle: Scott; Last: Bullers

4. DATE OF DEATH: Month: 5/31/1961; Day: ; Year: 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED — NEVER MARRIED — WIDOWED — DIVORCED —

8. DATE OF BIRTH: 3/29/59

9. AGE (If under 1 year, last birthday): Years: 2; Months: 2; Days: 2; Hours: ; Min.: ; UNDER 1 YEAR

10a. OCCUPATION (Kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Katanning, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Robert Bullers

14. MOTHER MAIDEN NAME: Virgina Ann Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Robert Bullers, Mayport, Pa. (FATHER)

18. CAUSE OF DEATH (Enter only one cause per line for a, b and c.)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 1st & 2nd Degree Burns of Face Body Arms & Legs — DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) — DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

INTERVAL BETWEEN ONSET AND DEATH: 4 hours

AUTOPSY PERFORMED? YES — NO X

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY X or CONTRIBUTING — CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Burned in fire in their Trailer Home

20c. TIME OF INJURY: Hour: 9:00 a.m. Month, Day, Year: May 31 1961

20d. INJURY OCCURRED: While at work — Not While at work X

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Frostburg Allegany Md

21. I certify that I took charge of the remains described above, held an Autopsy — Inquest on — Inquiry — and in my opinion death resulted from: Natural causes — Accident X Suicide — Homicide — Undetermined manner —

ACTUAL SIGNATURE: W O McLane

EXAMINER'S NAME (Type): W O McLane M D

CHIEF MEDICAL EXAMINER —
ASSISTANT MEDICAL EXAMINER —
DEPUTY MEDICAL EXAMINER X

Address (Street, city, town, or county): Frostburg Md

DATE SIGNED: May 31 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/3/1961

22c. NAME OF CEMETERY OR CREMATORY: Reynoldsville

22d. LOCATION (City, town, or county) (State): Reynoldsville PA.

23. FUNERAL DIRECTOR: GEORGE EICHHORN

ADDRESS: LONACONING, MD.

24a. REC'D BY REGISTRAR DATE: JUN 5 '61

24b. REGISTRAR'S SIGNATURE: Clifton L. Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5009 04999

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Resident lived before admission)
a. STATE: Penn.
b. COUNTY: Clarion
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mayport
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES NO

3. NAME OF DECEASED (Type or print): First Jeffrey Middle Phillip Last Bullers

4. DATE OF DEATH: Month 5/31/1961 Day Year 19

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED: NEVER MARRIED
8. DATE OF BIRTH: 8/5/1958
9. AGE (In years last birthday) IF UNDER 1 YEAR: 2 yr. Months 9 Days 26 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Brookville, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Bullers
14. MOTHER'S MAIDEN NAME: Virginia Ann Snyder
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Robert Bullers, Mayport, PA. (FATHER)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 1st & 2nd Degree Burns of Face
DUE TO (b): Body Arms & Legs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.: 4 hrs

WAS AUTOPSY PERFORMED? YES NO X

19. EXTERNAL CAUSES: PRIMARY X or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, Item 18): Burned in fire in Her Trailer Home
20c. TIME OF INJURY: Hour 8:00 a.m. Month May Day 31 Year 1961
20d. INJURY OCCURRED: While at work ☐ Not While at work X
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
(City or town): Frostburg (County): Allegany (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X, Examination ☐, and that death resulted from: Natural causes ☐, Accident X, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W O McLane
EXAMINER'S NAME (Type): W O McLane
M.D.
CHIEF MEDICAL EXAMINER ☐
ASSIST. NT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X
Address (Street, city, town or county): Frostburg Md
DATE SIGNED: May 31 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/3/1961
22c. NAME OF CEMETERY OR CREMATORY: Reynoldsville,
22d. LOCATION (City, town or county) (State): Reynoldsville, PA.

23. FUNERAL DIRECTOR: GEORGE EICHHORN
ADDRESS: LONACONING, MD.

24a. REC'D BY REGISTRAR DATE: JUN 5 '61
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the chief medical examiner or his deputy director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5010 — 05000

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): "Rural" Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): "Rural" Frostburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Isabelle — Middle: — Last: Burt
4. DATE OF DEATH: Month: May — Day: 14 — Year: 19 61
5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: November 29, 1878 — 9. AGE (In years last birthday): 82 yrs — IF UNDER 1 YEAR, IF UNDER 24 HRS: Months / Days / Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Nova Scotia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James McElvie
14. MOTHER'S MAIDEN NAME: Catherine Frazier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Walter Gardner — Address: "Rural" Frostburg, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — (b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from [illegible] 19[illegible], to [illegible] 19[illegible] that (I) (we) last saw the deceased alive on [illegible] 19[illegible] and that death occurred at [illegible] M. from the causes and on the date stated above

22a. SIGNATURE
M.D. ATTENDING PHYS. ☒ MEDICAL DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/17/61
23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery
23d. LOCATION (City, town, or county, State): Moscow, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn
ADDRESS: Lonaconing, Md.
25a. REC'D BY REGISTRAR DATE: MAY 17 '61
25b. REGISTRAR'S SIGNATURE: Esther L. Frazier

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5011 — 05001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be removed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4 15M 9/59

1. PLACE OF DEATH — a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN: 1b: I/I4/59
   d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
   d. STREET ADDRESS: 313 Carolina Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: Buskey

4. DATE OF DEATH: Month: May — Day: 7 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/28/1873

9. AGE (In years last birthday): 88 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Ownhome

11. BIRTHPLACE (State or foreign country): Maryland Cumberland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John T. Griffin

14. MOTHER'S MAIDEN NAME: Laura V. Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: P.O.Box 599 Cumberland, Md. Allegany County Infirmary records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO (b): Cerebral Arteriosclerosis — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Chronic Nephritis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Senile Deterioration

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from I/I4/59, 19, to 5/7/61, 19 that (I) (we) last saw the deceased alive on 5/6/61 7:30 PM that death occurred at ___ M, from the causes and on the date stated above

22a. SIGNATURE: James E. McLean M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 5/8/61

22c. PHYSICIAN'S NAME (Type): Dr. James E. McLean

22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-9-61

23c. NAME OF CEMETERY OR CREMATORY: St. Mary Cem

23d. LOCATION (City, town, or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James F. Scarpelli Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: MAY 1 '61

25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5012

CERTIFICATE OF DEATH

05002

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN Md: 2 days 19 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART DECATUR STREET

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL): CUMBERLAND
d. STREET ADDRESS: 213 W. 2nd ST.
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Marie JOSEPHINE; Middle: ; Last: CALVETTO
4. DATE OF DEATH: Month: 5; Day: 27; Year: 1961

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: #3/11/89
9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Ownhome
11. BIRTHPLACE (City or Town, County & State, or Foreign Country): ITALY Crecchio Chiete
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ANTHONY BAZEELI (DECEASED)
14. MOTHER'S MAIDEN NAME: Mary Darocco (DECEASED)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: CHART
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Cherrie Myrocarditis	10 yrs
DUE TO (b)	Uremia	10 yrs
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I: Osteo - Arthritis

IF WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year: 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.); City or town:

21. I certify that (I) (this hospital) attended the deceased from 1950, 19, to 5-27, 1961, that (I) (we) last saw the deceased alive on 5-27 1961 and that death occured at 6:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Dr. J. T. Johnson, M.D.
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type, M.D): DR. J. T. JOHNSON M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22d. ADDRESS: 16 GREEN STREET CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-31-61
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City, town or county; State): Cumberland, Md

24. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli
ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR: DATE 31 '61
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5013

CERTIFICATE OF DEATH

05003

M

I

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c LENGTH OF STAY IN 1b: 11 DAYS
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived, if institution resident give former residence)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 428 SEYMOUR STREET
e IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First VIOLET Middle G. Last CLAY

4. DATE OF DEATH: Month MAY Day 9, Year 1961

5. SEX: FEMALE
6 COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8 DATE OF BIRTH: DECEMBER 5, 1908
9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11 BIRTHPLACE (County & state or foreign country): CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: JAMES PAGUE
14. MOTHER'S MAIDEN NAME: GEORGIANA MC KINNEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES. (Yes, no, or unkown) (If yes give war or dates of service): no
16 SOCIAL SECURITY NO
17 INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b and c.)
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
DUE TO (b) Carcinoma of Breast
DUE TO (c) Post mastectomy Metastasis
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Left Mastectomy for Carcinoma Sept 1960
19. WAS AUTOPSY PER ORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) [ ]
20b DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II at item 18)
20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 7, 1960 to May 9, 1961 that (I) (we) last saw the deceased alive on May 9 1961, and that death occured at 9:05 AM from the causes and on the date stated above

22a SIGNATURE: Clay E Durrett M D
ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]
22b DATE SIGNED: 5/11/1961
22c. PHYSICIAN'S NAME (Type): DR. CLAY E. DURRETT
22d. ADDRESS: 303 GRAND AVE., CUMBERLAND, MD.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 5-11-1961
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d LOCATION (City, town or county) State: Cumberland Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.
25a REC'D BY REGISTRAR DATE: MAY 15 '61
25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05004

1. PLACE OF DEATH — a. COUNTY: 5014 ALLEGANY — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND — c. LENGTH OF STAY IN 1b: MARYLAND 11 DAYS — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: ALLEGANY — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MARYLAND — d. STREET ADDRESS: 303 PENNSYLNANIA AVE. CUMBERLAND, — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE — Middle G. — Last CLINE

4. DATE OF DEATH: Month 5 — Day 25 — Year 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-27-92

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Ownhome

11. BIRTHPLACE (City or Town, County & State, or Foreign Country): Elk Garden WEST, VIRGINIA

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: GEORGE WARNER(DECEASED)

14. MOTHER'S MAIDEN NAME: SUSAN KENNEY(DECEASED)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-22-6718

17. INFORMANT — Address: Thomas A. Cline Cumberland, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Cardiac or Pulmonary Infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

54 X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Decompensation — Years

DUE TO (c) Operation - abdominal - perineal resection — 6 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

Carcinoma return extending into Vagina

MEDICAL CERTIFICATION

20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. City or town — State

21. I certify that (I) (this hospital) attended the deceased from 1960, 19 to 5-25, 1961 that (I) (we) last saw the deceased alive on 5-25, 1961, and that death occurred at M, from the causes and on the date stated above

22a. SIGNATURE: Carlton Brinsfield M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 5-27-61

22c. PHYSICIAN'S NAME (Type): CARLTON BRINSFIELD M.D. — 22d. ADDRESS: 232 BALTIMORE AVE. CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 5-29-61 — 23c. NAME OF CEMETERY OR CREMATORY: St Patrick Cem. — 23d. LOCATION (City, town or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James F. Scarpelli Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: MAY 31 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5015 — 05008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 16 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL — WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 31 MEMORIAL AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: SUDIE — Middle: Virginia — Last: CRUMITT

4. DATE OF DEATH: Month: MAY — Day: 11, — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: FEBRUARY 6, 1882

9. AGE (In years last birthday) 79 yrs. (IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State or foreign country): ~~VIRGINIA~~ Brunswick, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: PAUL LONG

14. MOTHER'S MAIDEN NAME: MARY FRANCIS VALENTINE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO. None

17. INFORMANT (Address): MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Hepatitis coma	4 days
DUE TO (b)	Jaundice	17 days
DUE TO (c)	Portal cirrhosis	?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: coronary arteriosclerosis; myocardial fibrosis; cont'd. Lt. ventricular hypertrophy; pulmonary fibrosis; cont'd. calcification aorta; hypertension

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/25 ., 19 61 to 5/11 ., 19 61, that (I) (we) last saw the deceased alive on 5/11 ., 19 61, and that death occured at 9:10A .M. from the causes and on the date stated above.

22a. SIGNATURE

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ M.D.

22b. DATE SIGNED 5/12/61

22c. PHYSICIAN'S NAME (Type): DR. SAMUEL M. JACOBSON

22d. ADDRESS: 50 PERSHING ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/13/61

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

23d. LOCATION (City, town or county, (State)): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John J. Hafer, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: MAY 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5016

CERTIFICATE OF DEATH

05007

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN Md: MARYLAND 3yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 523 Cumberland, Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 523 Cumberland Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Genevieve; Middle: R.; Last: Cullen

4. DATE OF DEATH: Month: May; Day: 27; Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-27-1893

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Waitress

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (City or Town & State or foreign country): Allegany County, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Timothy Cullen

14. MOTHER'S MAIDEN NAME: Bridget Donahue

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service: No

16. SOCIAL SECURITY NO: None

17. INFORMANT: 192-09-8643 Mrs. John M. Bryson, Address: 523 Cumberland St., Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 4 mos.

DUE TO (b): Carcinoma of Cervix — 22 mos

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or Town

21. I certify that (I) (this hospital) attended the deceased from 8 Aug 1959 to 27 May, 1961 that (I) (we) last saw the deceased alive on 26 May 1961, and that death occured at 7½ PM, from the causes and on the date stated above.

22a. SIGNATURE: James G. Stegmaier M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-29-61

22c. PHYSICIAN'S NAME (Type): James G. Stegmaier, M.D.

22d. ADDRESS: 132 S. Centre St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/30/61

23c. NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery

23d. LOCATION City town or county: Frostburg Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Lucille H. Mortimer

Hafer Funeral Home, 25 E. Main, Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: JUN 2 '61

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 24 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health. Burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5017

CERTIFICATE OF DEATH

05008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complet[illegible] ed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 shou d be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN MARYLAND: 15 Hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Resident of [illegible] Division)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: Box 110, R.D. #2 (Zihlman)
IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First JOHN Middle FRANCIS Last CUNNINGHAM
4. DATE OF DEATH: Month 5 Day 29 Year 19 61.
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 6-11-15
9. AGE (In years last birthday): 45 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Kaiser Alum. Refractories
11. BIRTHPLACE (City & State or Foreign country): Zihlman
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thomas H. Cunningham
14. MOTHER'S MAIDEN NAME: Mary Jane Allen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown): Yes
16. SOCIAL SECURITY NO.: W.W.#2 212-10-6308
17. INFORMANT: Miss Gertrude Cunningham, Address: Apt. 105 19 Ridge Rd. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal Bronko Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO: Emphysema & Pulmonary Fibrosis — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO: [illegible]
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION:
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT WAS INJURY NOT OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED: Enter nature of injury in Part I or Part II.
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town

21. I certify that (I) (this hospital) attended the deceased from May 28 1961 to May 29 1961, that (I) (we) last saw the deceased alive on May 28 1961 and that death occurred at [illegible] M, from the causes and on the date stated above.

22a. SIGNATURE: W O McLane
22b. DATE SIGNED: May 30 1961
ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]
22c. PHYSICIAN'S NAME (Type): W O McLane MD
22d. ADDRESS: Frostburg Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-31-61
23c. NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery
23d. LOCATION (City, town or county, State): Frostburg Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Hafer Funeral Home, 23 E. Main, Frostburg, Md.
25a. RECEIVED BY REGISTRAR: DATE JUN 2 '61
25b. REGISTRAR'S SIGNATURE: Arthur E. Hiers

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5013

CERTIFICATE OF DEATH

05009

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN: MARYLAND 32 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MOOREFIELD
d. STREET ADDRESS:
IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MINNIE Middle Last DASHER

4. DATE OF DEATH: Month MAY Day 19, Year 1961.

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: NOVEMBER 24, 1887

9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City & State or foreign country): DURGON, W.VA.

12. CITIZEN OF WHAT COUNTRY? U. S.A.

13. FATHER'S NAME: AMBY HARPER

14. MOTHER'S MAIDEN NAME: ELLEN JUDY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronal Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO (b): A.S. and Hypertensive heart disease — 3 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Ver. arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Enlarged prostate, Complicated by intestinal hemorrhage

19. WAS A TOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS INJURY NOT OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)?

20b. DESCRIBE HOW INJURY OCCURRED: Enter nature of injury in Part I or Part II of item 18

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town, (County), State,

21. I certify that (I) (this hospital) attended the deceased from May 2, 19 62 to May 2, 19 62 that (I) (we) last saw the deceased alive on May 2 19 62 and that death occured at 8:00 AM from the causes and on the date stated above

22a. SIGNATURE: W. A. Van Ormer M.D.

22b. DATE SIGNED:

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): DR. W. A. VAN ORMER

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL CREMATION, REMOVAL Specify: Burial

23b. DATE THEREOF: May 21-1961

23c. NAME OF CEMETERY OR CREMATORY:

23d. LOCATION (City, town or county): Moorefield-W.Va.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: [illegible]

25a. RECD BY REGISTRAR DATE: MAY 31 '61

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5019

05010

1 PLACE OF DEATH a. COUNTY: Allegany — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany Street

d. STREET ADDRESS: Allegany Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas Middle: Baker Last: Dick

4. DATE OF DEATH: Month: May Day: 23 Year: 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 6, 1884

9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Insurance Agent

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Dick

14. MOTHER'S MAIDEN NAME: Margaret Schulyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO:

17. INFORMANT Address: Mrs. Thomas Dick "Wife" Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Cardiovascular Renal Disease — years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Jan. 1955 to May 23, 1961 that (I) (~~we~~) last saw the deceased alive on May 22 19 61 and that death occurred at 2:30 A.M. from the causes and on the date stated above

22a. SIGNATURE: John B. Davis, M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): John B. Davis, MD

22d. ADDRESS: 2 Broadway, Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/26/61

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City, town or county) State: Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: George Eichhorn Lonaconing, Md.

25a. RECD BY REGISTRAR DATE: MAY 26 61

25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician and completely filled. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9 59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5020 05011

M

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 5 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7 N. Grant Street

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 7 N. Grant Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jessie — Middle: Lucille — Last: Engle

4. DATE OF DEATH: Month: May — Day: 20th, — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 30th, 1891

9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.-Pan Packager

10b. KIND OF BUSINESS OR INDUSTRY: Aluminum Co.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Murray

14. MOTHER'S MAIDEN NAME: Susan Arnold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 280-22-0302

17. INFORMANT: Elmer Engle, Address: 7 N.Grant St.Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Stomach Carcinoma
DUE TO: (b) Arteriosclerotic Cirrhosis
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO: (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: o m. p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 6-1, 19[illegible] to [illegible], 19[illegible] that (I) (we) last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M. from the causes and on the date stated above

22a. SIGNATURE: [signature] M.D

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 5/[illegible]/61

22c. PHYSICIAN'S NAME (Type): H. C. Diehl

22d. ADDRESS: 39 W. Main Street, Frostburg, Md.

23a. BURIAL CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-23-61

23c. NAME OF CEMETERY OR CREMATORY: F'burg. Memorial Park

23d. LOCATION (City, town, or county) (State): Frostburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [signature]

ADDRESS: Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: MAY 24 1961

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal and in any event, within 72 hours after death

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5021 — 05012

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 20 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution Resident before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: MORGAN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give location): PA W PAW
d. STREET ADDRESS: c/o POSTMASTER
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First ROBERT; Middle C.; Last FAWVER
4. DATE OF DEATH: Month MAY; Day 19; Year 1961

5 SEX: MALE
6 COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8 DATE OF BIRTH: JUNE 16, 1892
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min: 68 yrs.

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (City & State or foreign country): MARTINSBURG, W. VA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM G. FAWVER
14. MOTHER'S MAIDEN NAME: MARY E. AMBROSE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO: 232-10-4837
17 INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Left Lung — INTERVAL BETWEEN ONSET AND DEATH: Probably 3-4 yrs.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS HOMICIDE OR SUICIDE OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of item 18
20c TIME OF INJURY Hour a.m. p.m. Month Day 19 Year
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County)

21 **I certify** that (I) (this hospital) attended the deceased from April 1959 10:15 P.M. May 19, 1961, that (I) (we) last saw the deceased alive on May 19, 1961, and that death occured at ... P.M. from the causes and on the date stated above.

22a. SIGNATURE: Calvin Y. Hadidian, M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED
22c PHYSICIAN'S NAME (Type): DR. CALVIN Y. HADIDIAN
22d ADDRESS: WASHINGTON & CUMBERLAND STS., CUMBERLAND, MD.

23a. BURIAL CREMATION REMOVAL (Specify): BURIAL
23b DATE THEREOF: 5/23/61
23c NAME OF CEMETERY OR CREMATORY: CAMP HILL
23d LOCATION (City, town or county): FAW/PAW W. VA.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: PARKS JOHNSON BERKELEY SPGS. W. VA.
25a. REC'D BY REGISTRAR DATE: MAY 23 '61
25b. REGISTRAR'S SIGNATURE: Thos. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute [illegible] certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

M — 5022 — Reg. Dist. No. 05013

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural near Oldtown
d. STREET ADDRESS: Rt. #1, Oldtown
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First RICHARD — Middle LEE — Last FLETCHER
4. DATE OF DEATH: Month May — Day 3 — Year 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 12, 1951
9. AGE (In years last birthday): 10 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: Public School
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

I

13. FATHER'S NAME: Richard W. Fletcher
14. MOTHER'S MAIDEN NAME: Betty Kinser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Richard W. Fletcher, Rt.#1, Oldtown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MACERATION OF BRAIN, INTRACRANIAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
119.0
DUE TO (b): GUNSHOT WOUND — 2 Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Accidental gunshot wound of right nostril
20c. TIME OF INJURY — Hour — a.m. p.m. — Month, Day, Year: 5:30 p.m. May 1 19 61
20d. INJURY OCCURRED — While at work [ ] Not while at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm
20f. (City or town) (County) (State): Oldtown, Alleg. Maryland

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and find that death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER [ ] — ASSISTANT MEDICAL EXAMINER [ ] — DEPUTY MEDICAL EXAMINER [X] — DATE SIGNED: May 3, 1961
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/6/61
22c. NAME OF CEMETERY OR CREMATORY: Twigg Cemetery
22d. LOCATION (City, town, or county) (State): Fletcher Farm, Near Oldtown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR — DATE: 5 4 61
24b. REGISTRAR'S SIGNATURE

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5023

CERTIFICATE OF DEATH

05014

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 1821 BEDFORD ROAD
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First GEORGE Middle C Last FREY

4. DATE OF DEATH: Month 5/ Day 18/ Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 4/11/75

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Embalmer & Funeral Director

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City & State or foreign country): MARYLAND Cumberland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Conrad Frey

14. MOTHER'S MAIDEN NAME: Margaret Seiss

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO

17. INFORMANT: CHART
Address

18. CAUSE OF DEATH [Enter only one cause per line for a, b, and c.]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Cardio Vascular Disease
DUE TO
(c): Myocardial - Infarction

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. | Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/13 1961, to 5/18, 1961 that (I) (we) last saw the deceased alive on. 5/18 1961, and that death occured at 8:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Leo H. Ley, Jr.

M.D. ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 5/18/61

22c. PHYSICIAN'S NAME (Type): DR. LEO LEY, JR

22d. ADDRESS: 456 N CENTER STREET

23a. BURIAL, CREMATION, REMOVAL (Specify): Mausoleum

23b. DATE THEREOF: 5-20-61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli

ADDRESS: Cumberland, Md

25a. REC'D BY REGISTRAR DATE MAY 23 '61

25b. REGISTRAR'S SIGNATURE: Mathew E. Prasch

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5024

CERTIFICATE OF DEATH

Reg. Dist. No. 05015

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 607 Lynn St.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 607 Lynn St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OLIA — Middle: BERNADETTE — Last: GARRETT

4. DATE OF DEATH: Month: May — Day: 2 — Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 7, 1899
9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Deer Park, Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John R. Browning
14. MOTHER'S MAIDEN NAME: Lucinda J. Walters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 216-22-6536
17. INFORMANT: Mr. Charles Garrett — Address: 607 Lynn St., Cumb.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): [illegible]
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible] to [illegible], that I last saw the deceased alive on [illegible], and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph W. Ballin M.D. ADDRESS (Street, city or town, state): [illegible] DATE SIGNED: 5-2-61

PHYSICIAN'S NAME (Type): Ralph W. Ballin M. D. 62 Greene St. Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/5/61
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George, ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: MAY 8 61
24b. REGISTRAR'S SIGNATURE: Cathrine L. Rinner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5025 Reg. Dist. No. 05016

1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN 1b: 1 Wk.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
d. STREET ADDRESS 700 Brookfield Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICHARD Middle EVERETT Last GROVES
4. DATE OF DEATH: Month May Day 4, Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: June 4, 1928
9. AGE (In years last birthday): 32 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mech. Dept.
10b. KIND OF BUSINESS OR INDUSTRY: K-S Tire Company
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Everett C. Groves
14. MOTHER'S MAIDEN NAME: Mildred Harrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 46-48 50-51
16. SOCIAL SECURITY NO.: 216-22-6550
17. INFORMANT Address: Gerald Groves, Frostburg, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, Right — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b) Coronary Sclerosis — ----

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Benedict Skitarelic M.D.
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED May 4, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 6, 1961
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR DATE MAY
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5026 — Reg. Dist. No. 05017

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 hr. 20 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 216 CENTRAL AVE.
e. RESIDENCE ON FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First BERNARD — Middle Golden — Last HARDY
4. DATE OF DEATH: Month 5 — Day 22 — Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 21,1895
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired employee - Washington Terminal R.R.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Hardy
14. MOTHER'S MAIDEN NAME: Mary Hess

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes — (If yes, give war or dates of service): W W I
16. SOCIAL SECURITY NO: 718-14-9748
17. INFORMANT: Mrs. Josephine Hardy — Address: 216 Central Avenue, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 2-4 Hrs.
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): CORONARY SCLEROSIS — ----
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — DATE SIGNED
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D. — DEPUTY MEDICAL EXAMINER ☒ — May 22, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 26,1961
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ruth E. Silcox Cumberland Maryland
24a. REC'D BY REGISTRAR DATE: MAY 25 '61
24b. REGISTRAR'S SIGNATURE: Clifton L. Firaus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5027

Reg. Dist. No. 05018

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMB[illegible]LAND
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: WEST VIRGINIA — b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL RIDGELEY
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ADAM — Middle: — Last: HERRICK

4. DATE OF DEATH: Month: 5 — Day: 31 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/29/87

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Self Emp.

11. BIRTHPLACE (State or foreign country): W.VA.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN ADAM HERRICK

14. MOTHER'S MAIDEN NAME: MARY ABE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: CHART — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion, left — INTERVAL BETWEEN ONSET AND DEATH: 3 days

420-1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Thrombosis — 3 days

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

DATE SIGNED: May 31, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-2-61

22c. NAME OF CEMETERY OR CREMATORY: Abe Cemetery

22d. LOCATION (City, town, or county) (State): Wiley Ford, W.Va.

23 FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli
ADDRESS: Cumberland, Md.

24a. RECEIVED BY REGISTRAR
DATE: JUN 2 '61

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal

VS A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5028 — 05019

1 PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN: MARYLAND 32 yrs. | 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE Where deceased lived. If institution: Resident (Inmate)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give name of town): Frostburg
d. STREET ADDRESS: 62 Spring Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE Middle VIOLA Last HILL
4. DATE OF DEATH: Month 4/ Day Year 19
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct.10-1921
9. AGE In last birthday: 39 yrs.
UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Other people
11. BIRTHPLACE (City & State or foreign country): Midlothian, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Alfred Togans
14. MOTHER'S MAIDEN NAME: Eloise Frazier
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: Robert Hill, 62 Spring St., Frostburg, Md.

18. CAUSE OF DEATH (Enter only one cause per line for a, b and c.)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO (b): arteriosclotic Heart disease — 1 Year
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO (c): Diabetes mellitus — Indef.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter name of fm, yes in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town
County
State

21. I certify that I) (~~the deceased~~) attended the deceased from April, 1955 to May 25, 1961 that (I) (we) last saw the deceased alive on May 25 1961 and that death occured at 7:20 P.M. from the causes and on the date stated above

22a. SIGNATURE: John B. Davis, M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/27/61
22c. PHYSICIAN'S NAME (Type): John B. DAVIS, MD
22d. ADDRESS: 2 BROADWAY, FROSTBURG, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-28-61
23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park
23d. LOCATION (City, town or county, State): Frostburg Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Hafer Funeral Home
ADDRESS: 23 E. Main, Frostburg, Md.
25a. RECD BY REGISTRAR
25b. REGISTRAR'S SIGNATURE: Edward L. Thomas
DATE: MAY 31 '61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5929 — 05020

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND MD
c. LENGTH OF STAY IN 1b: 5DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2 USUAL RESIDENCE Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): FROSTBURG, MARYLAND
d. STREET ADDRESS: 44 WEST COLLEGE AVE
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ANNA	C.	HOTT	5	25	1961

5 SEX	6 COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
FEMALE	WHITE	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	5-30-1897	63 yrs				

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (City or County & State or foreign country): WEST, VIRGINIA
12 CITIZEN OF WHAT COUNTRY? UNITED STATES

13 FATHER'S NAME: JOHN J. REILLY (DECEASED)
14. MOTHER'S MAIDEN NAME: SARAH (MALLOW) REILLY (DECEASED)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Alfred Hott — Address: 44 College Ave Frostburg Md — Relationship: Father

18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): UREMIA — 2 days
DUE TO (b): Hepatitis
DUE TO (c): Hepatitis
Conditions, if any, which gave rise to above stated underlying cause last: Cirrhosis of Liver

INTERVAL BETWEEN ONSET AND DEATH: 10 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a ACCIDENT, HOMICIDE, SUICIDE, UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Not necessary if injury is in Part I or Part II, Item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) County (State)

21 I certify that (I) (the hospital) attended the deceased from [illegible] to 5/27, 19 61 that (I) (we) last saw the deceased alive on 5/27 19 61, and that death occured at 7:A M, from the causes and on the date stated above.

22a SIGNATURE: [signature] M.D.
22b. DATE SIGNED: 5/-/61
ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS. [ ]
22c. PHYSICIAN'S NAME (Type): S.G.WESIMAN M.D.
22d. ADDRESS: 59 GREENE STREET, CUMBERLAND, MD (State)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial 5-27-61
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION City, town or county

24 FUNERAL DIRECTOR'S SIGNATURE: J. P. Hurst
ADDRESS: Frostburg Md
25a. RECEIVED BY REGISTRAR DATE: MAY 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5030

05021

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 3 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 207 Laing Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 207 Laing Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lizetta — Middle: Elizabeth — Last: Johnson

4. DATE OF DEATH: Month: May — Day: 1 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 24, 1876

9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): New York City

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Martin Roedel

14. MOTHER'S MAIDEN NAME: Elizabeth Fight

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Charles W. Johnson — Address: 207 Laing Avenue, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:

154-X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Carcinoma of Colon

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour: — a. m. / p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible] 19[illegible] to [illegible] 19[illegible] that ( ) (we) last saw the deceased alive on [illegible] 19[illegible] and that death occurred at 3:02 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Fuller B. Whitworth M.D.

22b. DATE SIGNED

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22c. PHYSICIAN'S NAME (Type): Fuller B. Whitworth, M.D.

22d. ADDRESS: 123 Bedford St. Cumberland, Md.

23a. BURIAL CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: May 3, 1961

23c. NAME OF CEMETERY OR CREMATORY: Hill Grove Cemetery

23d. LOCATION (City, town, or county): Connellsville — State: Penna.

24. FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox — ADDRESS: Cumberland Maryland

25a. REC'D BY REGISTRAR DATE: MAY 3 '61

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5631 Reg. Dist. No. 05022

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Barrelville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GEORGE — Middle: CLINTON — Last: KELLEY

4. DATE OF DEATH: Month: May — Day: 29, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 1, 1892

9. AGE (In years last birthday): 69 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (State or foreign country): Gilmore, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James B. Kelley

14. MOTHER'S MAIDEN NAME: Martha Jane Boyer

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): Yes — (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 208-09-5660

17. INFORMANT — Address: Mrs. George C. Kelley, Barrelville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): COR PULMONALE, MARKED — INTERVAL BETWEEN ONSET AND DEATH: Years

523.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): SILICOSIS; EMPHYSEMA — ?

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia, left lower lobe; terminal

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D. — May 29, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 31, 1961

22c. NAME OF CEMETERY OR CREMATORY: St. Partick's Catholic

22d. LOCATION (City, town, or county) (State): Mt. Savage, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Md.

24a. REC'D BY REGISTRAR — DATE: JUN 2 1

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5032

CERTIFICATE OF DEATH

05023

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: GOLDEN LANE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: KATHRYN Middle: E. Last: KIRCHNER

4. DATE OF DEATH: Month: MAY Day: 17, Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 29, 1953

9. AGE (In years last birthday): 7 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ROY KIRCHNER

14 MOTHER'S MAIDEN NAME: RUTH WILKES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16 SOCIAL SECURITY NO.:

17. INFORMANT Address: MEMORIAL HOSPITAL-CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Hemorrhagic childbirth — 9 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town / County / State

21. I certify that (I) (this hospital) attended the deceased from May 11, 1961 to May 17, 1961, that (I) (we) last saw the deceased alive on May 17, 1961, and that death occured at 10:10 P.M., from the causes and on the date stated above

22a. SIGNATURE: R. A. Reiter

22b. DATE SIGNED: May 17, 1961

M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22c. PHYSICIAN'S NAME (Type): DR. R. A. REITER

22d. ADDRESS: 112 BEDFORD ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/20/61

23c. NAME OF CEMETERY OR CREMATORY: Suhset Memorial

23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: John J. Hoppe

ADDRESS: Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: MAY 22 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5033

CERTIFICATE OF DEATH

65024

1 PLACE OF DEATH
a COUNTY: ALLEGANY — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: MARYLAND — b COUNTY: ALLEGANY

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND

c LENGTH OF STAY IN 1b: 15 DAYS

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

d. STREET ADDRESS: 1119 OLDTOWN RD.

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: GEORGE — Middle: HENRY — Last: KNIPPENBERG

4 DATE OF DEATH: MAY 9, 61

5 SEX: MALE — 6 COLOR OR RACE: WHITE — 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8 DATE OF BIRTH: OCT. 26, 1878 — 9 AGE (In years last birthday): 83 yrs — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED RAILROAD Boilermaker — 10b KIND OF BUSINESS OR INDUSTRY: B&O RR — 11. BIRTHPLACE (State or foreign country): Greenspring, W.Va. — 12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: HENRY KNIPPENBERG (DECEASED) — 14 MOTHER'S MAIDEN NAME: Lutisha Logsdon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT: PATIENTS CHART — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): generalized arteriosclerosis — DUE TO

(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) — (County) — (State)

21 I **certify** that (I) (this hospital) attended the deceased from 5-1, 19 61, to 5-2, 19 61 that (I) (we) last saw the deceased alive on 5-9, 19 61, and that death occurred at 11:30 A.M., from the causes and on the date stated above

22a SIGNATURE: L. Brings M.D. — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐ — 22z DATE SIGNED: 5/10/61

22c PHYSICIAN'S NAME (Type): LEWIS BRINGS, M.D. — 22d ADDRESS: 55 GREENE ST., CUMBERLAND, MD.

23a BURIAL CREMATION REMOVAL (Specify): Burial — 23b DATE THEREOF: 5/12/61 — 23c NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery — 23d LOCATION (City, town or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: John J. Hafer, Cumberland, Maryland — 25a REC'D BY REGISTRAR DATE: MAY 12 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Trail

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5034

Reg. Dist. No. 05025

1. PLACE OF DEATH
a. COUNTY: Allegany
MARYLAND
b. CITY OR TOWN (If outside corporate limits write R.F.D. and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 1 Hr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write R.F.D. and give nearest town): Barton
d. STREET ADDRESS: Main
e. IS HOUSE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James; Middle: Ellsworth; Last: Lamberson

4. DATE OF DEATH: Month: May; Day: 31; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 12th 1930

9. AGE (Years at last birthday): 31 yrs.

IF UNDER 1 YEAR: Months; IF UNDER 24 HRS: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Meat Cutter

10b. KIND OF BUSINESS OR INDUSTRY: Grocery Store

11. BIRTHPLACE (State or foreign country): Barton-Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Maurice B. Lamberson

14. MOTHER'S MAIDEN NAME: Louise Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-24-2006

17. INFORMANT: Jean E. Lamberson; Address: Barton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — Sudden

DUE TO (b): Coronary Sclerosis — ----

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W O McLane

M D CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): W. O. MC Lane

DATE SIGNED: May 31, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/3/61

22c. NAME OF CEMETERY OR CREMATORY: Mt. View

22d. LOCATION (City, town, or county) (State): Moscow Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. L. Boal

ADDRESS: Westernport, Md.

24a. REC'D BY REGISTRAR DATE

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

VS A1SME 5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5035 — 05028

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be ned by the hospito or attending physician.

TO FUNERAL DIRECTOR: After this cert ficate has been s gned by the attend ng physician and completely f ed, the funeral d rector, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and n any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1 PLACE OF DEATH — a COUNTY: Allegany — MARYLAND

2 USUAL RESIDENCE (Where deceased lived f institution Residence before admiss on) — a STATE: Maryland — b COUNTY: Allegany

b CITY OR TOWN (If outside corporate lim ts wr te RURAL and give nearest town): La Vale

c. LENGTH OF STAY IN 1b: 35 Yrs.

c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): X La Vale

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 352 Mc Henry Street

d. STREET ADDRESS: 352 Mc Henry Street

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ARTHUR — Middle CECIL — Last LANCASTER

4. DATE OF DEATH: Month May — Day 8, — Year 19 61

5 SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: July 19, 1895

9 AGE (In years last birthday): 65 yrs

IF UNDER 1 YEAR / IF UNDER 24 HRS — Months / Days / Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper

10b KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11 BIRTHPLACE (State or foreign country): Eckhart, Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Edward Lancaster

14 MOTHER'S MAIDEN NAME: Margaret Rephann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) Yes — (If yes give war or dates of service) WW I

16. SOCIAL SECURITY NO

17. INFORMANT — Address: Mrs. Arthur C. Lancaster, La Vale, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter on y one cause per line for (a) (b). and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last — (b) Carcinoma of the esophagus

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of n jury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o m. p m — Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 4-3- , 1961 to 5-8- , 1961 that (I) (we) last saw the deceased alive on 5-6- 1961, and that death occurred at 4A M, from the causes and on the date stated above

22a SIGNATURE: L Brings M D

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED

22c PHYSICIAN'S NAME (Type): LEWIS BRINGS

22d. ADDRESS: 57 Greene St. Cumberland Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: May 10, 1961

23c NAME OF CEMETERY OR CREMATORY: Porter Cemetery

23d LOCATION (City town or county) (State): Eckhart, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Maryland

25a. REC'D BY REGISTRAR — DATE: MAY 1 9

25b REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5036

CERTIFICATE OF DEATH

Reg. Dist. No. 5027

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft. Hill
c LENGTH OF STAY IN 1b: Lifetime
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: [illegible]rs Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d STREET ADDRESS: Walnut Level Farm
e IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First: Susan — Middle: G. — Last: Layman

4. DATE OF DEATH: Month: May — Day: 7th, — Year: 19 61

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: July 7th, 1877
9 AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10b KIND OF BUSINESS OR INDUSTRY: Own home
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: John N. Layman
14. MOTHER'S MAIDEN NAME: Anna Fazenbaker

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16 SOCIAL SECURITY NO: None
17. INFORMANT Address: J. Horace Layman, Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1960, 19 to May 7, 1961, that I last saw the deceased alive on May 6, 1961, and that death occurred at 5:00 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: W O McLane M D
ADDRESS (Street, city or town, state): Frostburg Md
DATE SIGNED: May 9 1961

PHYSICIAN'S NAME (Type): W. O. McLane, II — 167 E. Main Street, Frostburg, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 5-9-61
22c NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Park
22d LOCATION (City, town, or county) (State): Frostburg, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Joseph R Bruni — ADDRESS: Frostburg, Md.
24a REC'D BY REGISTRAR DATE:
24b REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5037 — 05028

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 33 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: RT. #2, WILLIAMS ROAD
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First ALVIN — Middle J. — Last LEHMAN

4. DATE OF DEATH: Month MAY — Day 30, — Year 19 61

5. SEX: MALE — 6. COLOR OR RACE: WHITE — 7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: MAY 23, 1900

9. AGE (In years last birthday) 61 yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: B & O R. R.

11. BIRTHPLACE (City & State or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: OWEN ALVIN LEHMAN

14. MOTHER'S MAIDEN NAME: ELLEN BONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 214- 07- 1144

17. INFORMANT: Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. CAUSE OF DEATH [Enter only one cause per line for a, b, and c.]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 & hours

DUE TO (b): arteriosclerotic and Hypertensive cardiovascular disease. 2 years

Conditions, if any, which gave rise to (a) stating the underlying cause last. DUE TO (c): Gen. arteriosclerosis ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Herpes zoster, post, sacrum to coccyx, amputation mid-thigh 5/25/61

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED: Enter nature of injury in Part I or Part II of item 18

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day — Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. City, town — County — State

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 19 61, to May 30 19 61 that (I) (we) last saw the deceased alive on May 30 19 61, and that death occured at 7:30AM from the causes and on the date stated above.

22a. SIGNATURE: W. Albert Van Ormer — M.D. ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [ ]

22b. DATE SIGNED: 1 June 61

22c. PHYSICIAN'S NAME (Type): DR. W. A. VAN ORMER

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: June 2,1961 — 23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park — 23d. LOCATION (City, town or county — State): Cumberland Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox — ADDRESS: Cumberland, Maryland

25a. REC'D BY REGISTRAR — DATE: JUN 5 '61 — 25b. REGISTRAR'S SIGNATURE: Clinton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5038

CERTIFICATE OF DEATH

05029

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
c. LENGTH OF STAY IN: MARYLAND 10 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give street address or location): X CUMBERLAND
d. STREET ADDRESS: RT.#4, BOX 42
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First MARY Middle V. Last LONG

4. DATE OF DEATH: Month MAY Day 23 Year 1961

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8 DATE OF BIRTH: JULY 18, 1893
9 AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11 BIRTHPLACE (City & State or foreign country): W.VA. PETERSBURG
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN L. EVANS
14. MOTHER'S MAIDEN NAME: MARY J. BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16 SOCIAL SECURITY NO: 214-07-5481
17 INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): I dop the Thrombosis hypem Pneumonia
DUE TO (b): Arteriosclerotic Cardiac Disease
DUE TO (c):
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 weeks, years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Resident General Uremia Accident

17 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work [ ] Not While at work [ ]
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town County State

21. I certify that (I) (this hospital) attended the deceased from Aug. 1959 to May. 1961 that (I) (we) last saw the deceased alive on May 23 1961, and that death occurred at 1:00 PM, from the causes and on the date stated above.

22a SIGNATURE: G. Himmelwright
22b. DATE SIGNED: 5/23/61
M.D. ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]
22c. PHYSICIAN'S NAME (Type): G. OVERTON HIMMELWRIGHT
22d. ADDRESS: 133 VIRGINIA AVE., CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: May 26,1961
23c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery
23d LOCATION (City, town or county, State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. RECD BY REGISTRAR DATE: MAY 31 '61
25b REGISTRAR'S SIGNATURE: Curtis J. Fiery

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5039 05030

1. PLACE OF DEATH a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt.1,Frostburg
c. LENGTH OF STAY IN 1b: 15 Yrs.
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Rt.1, Frostburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna Middle: Mary Last: Madden
4. DATE OF DEATH: Month: May Day: 10th, Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 14th,1894
9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Demonstrator Sewing Machine
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ambrose Morris
14. MOTHER'S MAIDEN NAME: Sarah Louise Neus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 358-07-1074
17. INFORMANT: Miss Sarah Morris,Rt,1,Frostburg,Md. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 6 Mo
DUE TO (b): Hypertension — 1 year
DUE TO (c):

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960 19 -- , to May 10, 1961 that (I) (we) last saw the deceased alive on May 3 1961, and that death occurred at 7:34 M from the causes and on the date stated above.

22a. SIGNATURE: W.O. McLane M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: May 10 1961
22c. PHYSICIAN'S NAME (Type): W. O. McLane
22d. ADDRESS: 167 E. Main St.,Frostburg, Md.

23a. BURIAL CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-13-61
23c. NAME OF CEMETERY OR CREMATORY: St.Michael's Cemetery
23d. LOCATION (City, town, or county) State: Frostburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: Frostburg, Md.
25a. REC'D BY REGISTRAR DATE: MAY 12 '61
25b. REGISTRAR'S SIGNATURE: Esther L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4, 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5040

CERTIFICATE OF DEATH

5031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1 PLACE OF DEATH — a COUNTY: ALLEGANY — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) — a STATE: MARYLAND — b COUNTY: ALLEGANY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. SAVAGE
d STREET ADDRESS: RT. #1,
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ALBERT — Middle: T. — Last: MARTIN
4. DATE OF DEATH: Month: MAY — Day: 10 — Year: 1961

5 SEX: MALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: JAN. 5, 1905
9 AGE (In years last birthday): 56 yrs
IF UNDER 1 YEAR Months — IF UNDER 24 HRS Days Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DISABLED
10b KIND OF BUSINESS OR INDUSTRY: CELANESE
11 BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: WILLIAM MARTIN (DECEASED)
14 MOTHER'S MAIDEN NAME: ELIZABETH WATKINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No — None
16. SOCIAL SECURITY NO: 215-10-1244
17. INFORMANT: Wm.L. Martin — Address: PATIENTS CHART R.D.#1, Mt. Savage, Md

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): Coronary Thrombosis
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 4 Hrs. / 1 Yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c).
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour o m p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from January, 1961, to January 11, 1961, that (I) (we) last saw the deceased alive on January 9, 1961 and that death occurred at M. from the causes and on the date stated above.

22a SIGNATURE: B. M. Schindler M D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c PHYSICIAN'S NAME (Type): BLANE M. SCHINDLER, M.D.
22d. ADDRESS: 43 GREENE ST., CUMBERLAND, MD.

23a BURIAL CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 5-12-61
23c NAME OF CEMETERY OR CREMATORY: Methodist Cemetery
23d LOCATION (City town or county): Mt. Savage
State: Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Hafer Funeral Home, 23 E. Main, Frostburg, Md.
25a RECD BY REG STRAR DATE: MAY 15 61
25b REGISTRAR'S SIGNATURE

VR A1S (4) 15M 9 59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5041

CERTIFICATE OF DEATH

05032

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN THIS PLACE: 45 Minutes
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL ECKHART
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First SUSAN — Middle — Last MARTIRANO

4. DATE OF DEATH: Month MAY — Day 6 — Year 19 61

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 8, 1907

9. AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOUSEWORK

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: SALVATORE ZUMPANO

14. MOTHER'S MAIDEN NAME: VINCENZA ROSANOVA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: PATIENT'S CHART — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b): Arteriosclerotic cardio-vascular disease — 5 years
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year — Hour, a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-15, 1956, to 5-07, 1961 that (I) (we) last saw the deceased alive on 5-6 1961, and that death occurred at 9 P.M., from the causes and on the date stated above

22a. SIGNATURE: Peter G. Bucci M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 5-8-61

22c. PHYSICIAN'S NAME (Type): RALPH W. BALLIN, M.D.

22d. ADDRESS: 62 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-9-61

23c. NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery

23d. LOCATION (City, town or county): Frostburg, — State: Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Ricard Sr — ADDRESS: FROSTBURG, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 10 1961

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5042

CERTIFICATE OF DEATH

65033

M

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 5 S. MECHANIC STREET
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First GEORGIA Middle A. Last MAUS

4. DATE OF DEATH: Month MAY Day 16 Year 19 61

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 11-13-1886

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min: 74 yrs.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City & State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE PRATT

14. MOTHER'S MAIDEN NAME: ELLEN LARKIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO (b): Carcinoma Breast — 5 yrs

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS A TOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)

20b. DESCRIBE HOW INJURY OCCURRED Enter nature of injury in Part I or Part II of item 18

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)

20f. City or town County State

21. I certify that (I) (this hospital) attended the deceased from Feb , 19 61 to 5:45 P.M. May , 19 61 that (I) (we) last saw the deceased alive on May 16 19 61 and that death occured at 11: A.M. from the causes and on the date stated above.

22a. SIGNATURE: William P James M.D.

22b. DATE SIGNED: 5/18/61

22c. PHYSICIAN'S NAME (Type): DR. W. P. JAMES

ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS [ ]

22d. ADDRESS: 441 N. CENTRE STREET, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 19, 61

23c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery

23d. LOCATION (City, town or county): Cumberland

State: Md

24. FUNERAL DIRECTOR'S SIGNATURE: Louis Stein, Inc.

ADDRESS: Cumberland, Md.

25a. RECD BY REGISTRAR DATE: MAY 22 '61

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5043 — 05034

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 3 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission.)
a. STATE: Ohio
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairport Harbor
d. STREET ADDRESS: 307 6th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Deborah — Middle: Dianna — Last: McAlpine

4. DATE OF DEATH: Month: May — Day: 10 — Year: 19 61.

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-27-60

9. AGE (In years last birthday): 1 yrs. IF UNDER 1 YEAR: Months: 1 Days: IF UNDER 24 HRS.: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Cleveland, Ohio.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles L. McAlpine

14. MOTHER'S MAIDEN NAME: Phylis J. Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: None

Address: Charles L. McAlpine, Fairport Harbor, 307 6th Street, Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a: acute gastro-enteritis — INTERVAL BETWEEN ONSET AND DEATH: 7th days

DUE TO b: Severe dehydration — 1 day

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury, Part I or Part II.

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Y 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town: State:

21. I certify that I (~~saw the hospital~~) attended the deceased from 5-9, 1961 to 5-10 1961 that I (~~saw~~) last saw the deceased alive on 5-10 1961, and that death occurred at 1:38 A. M., from the causes and on the date stated above

22a. SIGNATURE: H. C. Diehl,

22b. DATE SIGNED: 5/10/61

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ M.D.

22c. PHYSICIAN'S NAME (Type): H. C. DIEHL, M.D.

22d. ADDRESS: Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-12-1961

23c. NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery

23d. LOCATION (City, town, county, state): Eckhart Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Montgomery

ADDRESS: Hafer Funeral Home, 23 E. Main, Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: MAY 15 '61

25b. REGISTRAR'S SIGNATURE: Arthur J. Francis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3044 — 65035

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 55yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 532 Necessity St.

2. USUAL RESIDENCE (Where deceased lived, If institution Resident give last usual residence)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give area): Cumberland
d. STREET ADDRESS: 532 Necessity St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lena; Middle: M.; Last: McArdle

4. DATE OF DEATH: Month: May; Day: 11; Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 7, 1886

9. AGE (If under 1 year, Months or Days; If under 24 hrs., Hours or Min.): 74 64 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Ownhome

11. BIRTHPLACE (City or County & State or Foreign Country): Everson, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Cornelius Miller

14. MOTHER'S MAIDEN NAME: Anna C. Pressman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. ##### Clara Leasure 532 Necessity

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO (b): arteriosclerotic heart disease — 2 years

DUE TO (c): generalized atherosclerosis — 2 years

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)

20f. City or town County State

21. I certify that (I) (this hospital) attended the deceased from 4-3- 1961 to 5-11- 1961 that (I) (we) last saw the deceased alive on 5-9- 1961, and that death occurred at 1 P.M. from the causes and on the date stated above.

22a. SIGNATURE: L Brings M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/12/61

22c. PHYSICIAN'S NAME (Type): Lewis Brings

22d. ADDRESS: 55 Green St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-14-61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or state): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli

ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR: DATE MAY 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur L Brings

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, with in 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5045 **CERTIFICATE OF DEATH** 05036

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible]4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 1 Wk.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL): Mt. Savage
STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOHN Middle: PATRICK Last: McGANN

4. DATE OF DEATH: Month: 5 Day: 5 Year: 19 61

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-24-1896

9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hour: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Worker

10b. KIND OF BUSINESS OR INDUSTRY: Kelly Tire Co.

11. BIRTHPLACE (City or county & State or foreign country): Frostburg

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James McGann

14. MOTHER'S MAIDEN NAME: Mary Durkin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If so give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: 220-18-7165 Miss Anna McGann, Address: 11 Washington St., Frostburg, Md. (Dght)

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Broncho-Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO (b): Secondary anemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury, if fracture, etc.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town)

21. I certify that I (~~this hospital~~) attended the deceased from 4-27, 1961 to 5-5, 1961 that (I) (~~last~~) saw the deceased alive on 5-4 1961 and that death occurred at 3:30 P.M., from the cause and on the date stated above

22a. SIGNATURE: H.C Diehl

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/6/61

22c. PHYSICIAN'S NAME (Type): H.C DIEHL, M.D.

22d. ADDRESS: FROSTBURG, Md.

23a. BURIAL, CREMATION, REMOVAL Specify: Burial

23b. DATE THEREOF: 5-8-61

23c. NAME OF CEMETERY OR CREMATORY: St. Patricks Cemetery

23d. LOCATION (City, town or county) (State): Mt. Savage, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]

ADDRESS: Hafer Funeral Home, 23 E. Main, Frostburg, Md.

25a. RECEIVED BY REGISTRAR

25b. REGISTRAR'S SIGNATURE: Esther L. Firma

DATE: MAY 9 '61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5046

CERTIFICATE OF DEATH

06295

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60 6/8/61 mnb

1 M I

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN Md: several years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where does deceased live, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg - rural
d. STREET ADDRESS: RD #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Augustus; Middle: W.; Last: Meyers

4. DATE OF DEATH: Month: May; Day: 9; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 10, 1906

9. AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 1 DAY: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): self-employed - Trucker

10b. KIND OF BUSINESS OR INDUSTRY: Trucking

11. EMPLOYED? (Yes, no, or unknown) (If yes give county & state): Somerset Co., Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Meyers

14. MOTHER'S MAIDEN NAME: Annie Platter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO: 214-03-5266

17. INFORMANT: Mrs. Anna M. Meyers, RD#1, Frostburg, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Insufficiency
DUE TO (b): Chr. Rheumatic Fever
DUE TO (c):
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 10 mo. years

415X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 4, 1960 to May 9, 1961, that (I) (we) last saw the deceased alive on May 9, 1961, and that death occured at 9:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: W O McLane

M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: May 9 1961

22c. PHYSICIAN'S NAME (Type): W. O. McLane, MD

22d. ADDRESS: Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 12, 1961

23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery

23d. LOCATION (City, town or county) (State): Rockwood, Somerset Co., Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: W. J. Wood

ADDRESS: Rockwood, Pa.

25a. REC'D BY REGISTRAR: DATE JUN 12 '61

25b. REGISTRAR'S SIGNATURE: [illegible]

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5047

CERTIFICATE OF DEATH

05037

M

1 PLACE OF DEATH a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 4/26/60
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Savage
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Emma — Middle: E. — Last: Miller

4. DATE OF DEATH: Month: May — Day: 9 — Year: 1961

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 12/10/1884
9 AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR OR UNDER 24 HRS: Months | Days | Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Own housework
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Charles Lehr
14 MOTHER'S MAIDEN NAME: Ellen Workman

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: P/O Box 599 Cumberland, Md. Allegany County Infirmary, records

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage — ?
DUE TO (b): Cerebral Arteriosclerosis — ?
DUE TO (c): Chronic Nephritis — >

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Chronic Myocardial Degeneration

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 **I certify** that (I) (the hospital) attended the deceased from 4/26/60 19 to 5/8/61 19 that (I) (we) last saw the deceased alive on 5/8/61 19 and that death occurred at 5:30 A.M. on the causes and on the date stated above

22a SIGNATURE: James E. McLean M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☒ STAFF PHYS ☒
22b DATE SIGNED: 5/9/61
22c PHYSICIAN'S NAME (Type): Dr. James E. McLean
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a BURIAL CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 5-13-61
23c NAME OF CEMETERY OR CREMATORY: St.George's Cemetery
23d LOCATION (City, town, or county) (State): Mt. Savage, Md.

24 FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: Frostburg, Md.
25a REC'D BY REGISTRAR DATE: MAY 12 '61
25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5048 — 05038

1 PLACE OF DEATH a COUNTY: Allegany — MARYLAND

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE: Maryland b COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport

c LENGTH OF STAY N 1b: 37 Yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 135 Front St.

d STREET ADDRESS: 135 Front

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Sarah — Middle: Catherine — Last: Moon

4 DATE OF DEATH: Month: May — Day: 26 — Year: 19 61

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Feb. 18, 1888

9 AGE (In years last birthday): 73 yrs

IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): XXXXXX

10b KIND OF BUSINESS OR INDUSTRY: XXXXXX

11 BIRTHPLACE (State or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Adam Whetzel

14. MOTHER'S MAIDEN NAME: Matilida Whetzel

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16 SOCIAL SECURITY NO:

17 INFORMANT: Ira Whetzel — Address: McCoole, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chr. Cardio Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last

(b) Obesity, Hypertension, Cerebral Sclerosis

DUE TO

(c) Diabetes Mellitus

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from _____, 19__, to _____, 19 that (I) (we) last saw the deceased alive on _____, 19 and that death occurred at 9 P.M. from the causes and on the date stated above

22a SIGNATURE: R W Reeves M D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 5/27/61

22c PHYSICIAN'S NAME (Type): Raymond W. Reeves, M.D.

22d ADDRESS: Westernport, Maryland

23a BURIAL CREMATION REMOVAL (Specify): Burial

23b DATE THEREOF: May 29, 1961

23c NAME OF CEMETERY OR CREMATORY: Philos Cem.

23d LOCATION (City town or county State): Westernport, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: E. L. Boal

ADDRESS: Westernport, Maryland

25a REC'D BY REGISTRAR DATE: MAY 31 '61

25b REGISTRAR'S SIGNATURE: Arthur S. Travis

VR A1S (4) ISM 9/59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5043 Reg. Dist. No. 05039

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 226 Carroll St.
e. IS RESIDENCE ON FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bernard — Middle: F. — Last: Myers
4. DATE OF DEATH: Month: May — Day: 17 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 12, 1889
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob L. Myers
14. MOTHER'S MAIDEN NAME: Jenny Bell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Miss Clara Myers — Address: Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO
(b): CORONARY SCLEROSIS — ----
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: May 17, 1961
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 19, 1961
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Louis Steinbe — ADDRESS: 117 Frederick St. Cumb. Md.
24a. REC'D BY REGISTRAR: DATE MAY 19 '61
24b. REGISTRAR'S SIGNATURE: Clifton E. Mace

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5050

CERTIFICATE OF DEATH

05048

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN: MARYLAND; 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: WEST VIRGINIA
b. COUNTY: ALLEGANY, MD.
CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): RURAL-KEYSER
ST. ADDRESS: ROUTE #3
e. IS RESIDENCE ON A FARM? YES [ ] NO [ ]

3. NAME OF DECEASED (Type or print): First THOMAS; Middle R.; Last O'HAVER

4. DATE OF DEATH: Month MAY; Day 11; Year 1961.

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]

8. DATE OF BIRTH: 10-26-1889

9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & state or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN W. O'HAVER

14. MOTHER'S MAIDEN NAME: MARY DARR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/10/61, 19, to 5/14/61, 19, that (I) (~~was not~~) last saw the deceased alive on 5/12/61 19, and that death occured at 8:15AM from the causes and on the date stated above.

22a. SIGNATURE: R. J. Williams M.D.

ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/15/61

23c. NAME OF CEMETERY OR CREMATORY: Gaste-Cem.

23d. LOCATION (City, town or county) (State): Garrett County Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Ed. Sowers

ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: MAY 12 '61

25b. REGISTRAR'S SIGNATURE: Wilma S. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5051 — 05041

1 (M)

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 5 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL, NEW MEMORIAL & WARWICK AVES.,

2. USUAL RESIDENCE (Where deceased lived, if Institution, Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: 213 SCHLEY STREET
   5. RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DORA — Middle: A. — Last: PARSONS

4. DATE OF DEATH: Month: MAY — Day: 2 — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 15, 1883

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): FROSTBURG, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN ASPINALL

14. MOTHER'S MAIDEN NAME: MARIE KAEFER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

I

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Uremia	3 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — b) DUE TO	Generalized arteriolosclerosis	years
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED: Enter nature of injury in Part I or Part II of item 18

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. City or town — (County) — State

21. **I certify** that (I) (this hospital) attended the deceased from April 30, 1961, to May 2, 1961, that (I) (we) last saw the deceased alive on May 2, 1961, and that death occurred 7:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: B. M. Schindler — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/3/61

22c. PHYSICIAN'S NAME (Type): BLANE M. SCHINDLER

22d. ADDRESS: 43 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 5, 1961

23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Pk.

23d. LOCATION (City, town or county): Frostburg

State: Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Louis Stein, Inc. Cumberland, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 8 '61

25b. REGISTRAR'S SIGNATURE: Clinton L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Fee 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5052 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Reg. Dist. No. 05042

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): DOA Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Vale
d STREET ADDRESS: Mc Kenzie Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SANDRA — Middle KAY — Last PENDERGAST

4. DATE OF DEATH: Month May — Day 9, — Year 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 19, 1960

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 5 Days; IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

(I)

13. FATHER'S NAME: John THomas Pendergast

14. MOTHER'S MAIDEN NAME: Rosetta Metzner

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT Address: John T. Pendergast, La Vale, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASPHYXIATION — INTERVAL BETWEEN ONSET AND DEATH: 4-6 Min.
DUE TO (b): ASPIRATION OF STOMACH CONTENTS — 4-6 Min.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ACUTE TRACHEOBRONCHITIS

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. — MAY 9, 1961

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 5/12/61

22c. NAME OF CEMETERY OR CREMATORY: St. Ambrose Catholic Cem.

22d LOCATION (City, town, or county) (State): Cresaptown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: MAY 12 '61

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5053 — 05043 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): National Highway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
d. STREET ADDRESS: 55 McCulloh St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MYRTLE — Middle: — Last: PFAFF

4. DATE OF DEATH: Month: 5 — Day: 18 — Year: 19 61

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 12-18-1913 — 9. AGE (In years last birthday): 47 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Davis
14. MOTHER'S MAIDEN NAME: Mary James

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 220-16-7029
17. INFORMANT: James C. Pfaff, 55 McCulloh St. — Address: Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): RUPTURED HEART; RUPTURED AORTA — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): CRUSHED CHEST — Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Injured in [illegible] accident
20c. TIME OF INJURY: Hour: [illegible] a.m. p.m. — Month, Day, Year: May 15 1961
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt. 40 E. of
20f. (City or town): Frostburg — (County): [illegible] — (State): [illegible]

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: W O McLane M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DATE SIGNED

EXAMINER'S NAME (Type): W.O. McLane, Jr. M.D. — 1st DEPUTY MEDICAL EXAMINER ☒ — May 19, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-21-61
22c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park
22d. LOCATION (City, town, or county): Frostburg — (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Curtis H. Hafer — ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.
24a. REC'D BY REGISTRAR — DATE: MAY 2 '61
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5054 — 65044

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg (Rural #1 Gilmore
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? Y. ___ NO [X]

3 NAME OF DECEASED (Type or print): First WILLIAM Middle THOMAS Last PRESTON

4. DATE OF DEATH: Month 5/31/1961 Day Year 19

5 SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 11/6/1901

9. AGE (Years if over 1 year last birthday / Months / Days / Hours / Min. if under 24 hrs): 59 yrs

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Barton, MD.

12 CITIZEN OF WHAT COUNTRY? U-S-A

13. FATHER'S NAME: Meschisk Preston

14. MOTHER'S MAIDEN NAME: Annie Crawford

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown), (If yes give war or dates of service): NO

16 SOCIAL SECURITY NO: 182-01-3566

17 INFORMANT: Mrs. William Preston, Gilmore, MD (WIFE)

Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction, Massive; old and recent — Interval between onset and death: 2-3 Hrs.
DUE TO (b): Coronary Sclerosis with thrombosis — -----
DUE TO (c):

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month Day Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy [X] Inspection [X] Inquiry [X]. In my opinion death resulted from. Natural causes [X]. Accident [ ]. Suicide [ ]. Homicide [ ]. Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ACTUAL SIGNATURE: W O McLane
EXAMINER'S NAME (Type): W O McLane M D
M.D. asst

Address (Street, city, town or county): Frostburg Allegany Md

DATE SIGNED: May 31 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/3/1961

22c. NAME OF CEMETERY OR CREMATORY: Old Coney Cemetery

22d. LOCATION (City, town, or country) (State): Lonaconing, MD.

23. FUNERAL DIRECTOR: GEORGE EICHHORN

ADDRESS: LONACONING, MD.

24a. REC'D BY REGISTRAR DATE: JUN 5 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5055

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05045

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 318 BEDFORD ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle A — Last RICE
4. DATE OF DEATH: May 17, 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 6, 1881
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT
10b. KIND OF BUSINESS OR INDUSTRY: GROCERY
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN N. RICE
14. MOTHER'S MAIDEN NAME: OLIVE WAGNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS. HAZEL RICE — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): SHOCK — INTERVAL BETWEEN ONSET AND DEATH: 36 Hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): COMPRESSION FRACTURE OF 2 nd. Thoracic Vert. 36 Hrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): STUMBLED, FELL AND STRUCK BACK
20c. TIME OF INJURY: 9 Hour p. m. — Month, Day, Year: MAY 16 1961
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME
20f. (City or town) CUMBERLAND (County) ALLEGANY (State) MARYLAND

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D. — May 17, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MAY 27, 1961
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEMETERY
22d. LOCATION (City, town, or county) CUMBERLAND, MD. (State)

23. FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.
24a. REC'D BY REGISTRAR DATE: MAY 22 61
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5056

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05048

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: Homes Apt. 12 C Fort Cumberland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Ellen — Last: Rice

4. DATE OF DEATH: Month: May — Day: 2 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 30, 1880

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Rowlesburg, W. Va.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Patrick Maloney

14. MOTHER'S MAIDEN NAME: Beatrice Burke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Gay Rice, Cumberland, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASPHYXIATION — INTERVAL BETWEEN ONSET AND DEATH: 5-10 Min.

DUE TO (b): PULMONARY HEMORRHAGE, MASSIVE — 5-10 Min.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): BRONCHIAL EROSION FROM CALCIFIED LYMPH NODE —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: May 2, 1961

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 5, 1961
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. RECORDED BY REGISTRAR
DATE: MAY 4 '61

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5057 05047

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
CITY OR TOWN (If outside corporate limits, write RURAL and give name of town): CUMBERLAND
STREET ADDRESS: 824 COLUMBIA AVENUE
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First JESSIE Middle Helen Last ROBINETTE
4. DATE OF DEATH: Month MAY Day 19, Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: MAY 26, 1909
9. AGE (In years) (If under 1 year, Months, Days; if under 24 hrs., Hours, Min.): last birthday 51 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.
11. BIRTHPLACE (City & State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: JOHN RAY
14. MOTHER'S MAIDEN NAME: AGNES TRUE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No,
16. SOCIAL SECURITY NO.
17. INFORMANT: MEMORIAL HOSPITAL - CUMBERLAND, MD.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170 X — Metastatic Carcinoma of Breast
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDER THE OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town, County, (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1960, to May, 1961, that (I) (we) last saw the deceased alive on May 19, 1961, and that death occured at 8:25AM from the causes and on the date stated above.

22a. SIGNATURE: G. Overton Himmelwright M.D.
22b. DATE SIGNED: 5/20/61
ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. PHYSICIAN'S NAME (Type): DR. G. OVERTON HIMMELWRIGHT
22d. ADDRESS: 133 VIRGINIA AVE., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/22/61
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City, town or county, (State)): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: H. Wayne George Cumberland, Md.
25a. REC'D BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
DATE MAY 23 '61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 24 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5253 Reg. Dist. No. 05048

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 323 Baltimore Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WADE KEY ETH — Middle: — Last: ROOT
4. DATE OF DEATH: Month: MAY — Day: 22, — Year: 19 61

5 SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 19, 1908
9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Prod. Manager
10b. KIND OF BUSINESS OR INDUSTRY: Schmidts Bakery
11. BIRTHPLACE (State or foreign country): Thomas, West Virginia
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: WILLIAM ROOT
14. MOTHER'S MAIDEN NAME: REBECCA SHAHAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 214-05-5086
17. INFORMANT: Mrs. W. K. Root, Cumberland, Md. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b): CORONARY SCLEROSIS — ----
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: May 22, 1961
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 25, 1961
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer — ADDRESS: Cumberland, Md.
24a REC'D BY REGISTRAR DATE: MAY 24 61
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with n 24 hours after death. If any delay is necessary, please execute th[illegible]ficate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral [illegible]ctor. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5059 Reg. Dist. No. 05049

M X I

1 PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 53 Marion St.

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 53 Marion St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First Lena Middle A. Last Ruppert

4 DATE OF DEATH: Month May Day 15 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Jan. 21, 1898
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Kitchen Help.
10b KIND OF BUSINESS OR INDUSTRY: Self
11 BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME: Jacob H. Ruppert
14 MOTHER'S MAIDEN NAME: Elizabeth Starmann

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, No, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17 INFORMANT: Miss Philomina Ruppert (Sister) Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): metastatic carcinoma left breast — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p m, 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-10-61, 19____, to 5-15-61, 19____, that I last saw the deceased alive on 5-9-61, 19____, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 16 Green St. Cumberland, Md DATE SIGNED: 5-16-61

PHYSICIAN'S NAME (Type): James T. Johnson Jr. M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: May 18, 1961
22c. NAME OF CEMETERY OR CREMATORY: SS Peter & Paul Cemetery
22d LOCATION (City, town, or county) (State): Cumberland, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc ADDRESS: 117 Frederick St, Cumb. Md.

24a REC'D BY REGISTRAR DATE: MAY 18 '61
24b REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5060 — 105050

1 PLACE OF DEATH
a COUNTY: ALLEGANY — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c LENGTH OF STAY IN 1b: 55 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SACRED HEART

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: MARYLAND
b COUNTY: ALLEGANY
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
d STREET ADDRESS: 439 BOND STREET
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY — Middle — Last SHARRETTE

4. DATE OF DEATH: Month MAY — Day 15 — Year 19 61

5 SEX: MALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 3-25-07
9 AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR OR UNDER 24 HRS: Months | Days | Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CITY OF CUMBERLAND
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: (DECEASED) John R. Sharretts
14 MOTHER'S MAIDEN NAME: (DECEASED) Mary E. Howearth

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or service) WW II
16 SOCIAL SECURITY NO: 214-05-8889
17 INFORMANT: CHART — Address

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Esophageal Varices — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Cirrhosis, hepatic
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

5210

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from ____ 19__ to 5-15 1961 that (I) (we) last saw the deceased alive on ____ 19__, and that death occurred at 4:10 P.M., from the causes and on the date stated above

22a SIGNATURE: Leo H. Ley Jr. M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 5/17/61
22c. PHYSICIAN'S NAME (Type): LEO H. LEY JR.
22d ADDRESS: 456 N. Centre St.

23a BURIAL CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 5/18/61
23c NAME OF CEMETERY OR CREMATORY: Summit Mem. Pk.
23d LOCATION (City, town or county): Cumberland MD (State)

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Lavio Stein Inc Cumb MD.

25a REC'D BY REGISTRAR: DATE MAY 19 '61
25b REGISTRAR'S SIGNATURE: Evelyn E. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5061

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05051

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)
a. STATE: W.VA — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PIEDMONT
d. STREET ADDRESS: 14 E HEMPSHIRE STREET
e. IS RES. LOCATED ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BLANCHE — Middle: — Last: SHERREN

4. DATE OF DEATH: Month: 5 — Day: 23 — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/12/93

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM DAWSON

14. MOTHER'S MAIDEN NAME: ANNA REYNOLDS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: CHART — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 7-10 Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — -----
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Intertrochanteric fracture right femur

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Fell in hall going from bed room to bath room

20c. TIME OF INJURY: Hour 9 a.m. p.m. — Month, Day, Year: May 9 1961

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Piedmont (County) Mineral (State) W. Va.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: May 23, 1961

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/26/61
22c. NAME OF CEMETERY OR CREMATORY: *Philos
22d. LOCATION (City, town, or county): Westernport (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: E. J. Boal
ADDRESS: Westernport, Md.

24a. REC'D BY REGISTRAR DATE: MAY 25 '61
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Page 6 is for burial, cremation, or removal.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5062 — 05952

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN: MARYLAND / 42 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution resident was before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 14 Shiller TERRACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle Jane Last SHIPLEY

4. DATE OF DEATH: Month MAY Day 27, Year 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-11-1884

9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Taylor

14. MOTHER'S MAIDEN NAME: Mary Sines

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: CHART — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure with Cerebral Edema — INTERVAL BETWEEN ONSET AND DEATH: 20 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Recent and Old Posterior Myocardial Infarction — 2 weeks (?)
DUE TO
(c) Arteriosclerotic (atherosclerotic)Cardiovascular dis Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
Diabetes Mellitus; Obesity; Acute occlusion, right popliteal vessels

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. City or town — County — (State)

21. I certify that I) (XXXXXXXX) attended the deceased from November ...., 1958 to May 27th, , 1961, that (I) (XX) last saw the deceased alive on May 26th, .. 1961 ., and that death occured at 2:20 a.m. from the causes and on the date stated above

22a. SIGNATURE: Wyand A. Doerner Jr

M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-28-61

22c. PHYSICIAN'S NAME (Typed): DR. WYAND DOERNER, JR., MD.

22d. ADDRESS: ALGONQUIN BLDG., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/29/61

23c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove Cemetery

23d. LOCATION (City, town or county), State: Near Cumberland Md

24. FUNERAL DIRECTOR'S SIGNATURE: John J Hafer

ADDRESS: Cumberland Md

25a. RECD BY REGISTRAR (DATE): MAY 31 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5063 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05053

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 20 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 815 MARYLAND AVE.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 805 MARYLAND AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle W. Last SHORT
4. DATE OF DEATH: Month MAY Day 18 Year 19 61

5 SEX: MALE
6 COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: [illegible]
9. AGE (In years last birthday): [illegible] yrs
IF UNDER 1 YEAR: Months [illegible] Days [illegible]
IF UNDER 24 HRS.: Hours [illegible] Min. [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARMAN
10b KIND OF BUSINESS OR INDUSTRY: RAILROAD
11. BIRTHPLACE (State or foreign country): W. VA.
12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JAMES SHORT
14. MOTHER'S MAIDEN NAME: ELIZABETH ADAMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO: UNKNOWN
17. INFORMANT Address: MRS. EDWARD CALLIS MT. LAKE PARK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CORONARY SCLEROSIS — INTERVAL: ----
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: May 18, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MAY 23,1961
22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEM.
22d LOCATION (City, town, or county) (State): ARLINGTON, VA.

23. FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT
ADDRESS: CUMBERLAND, MD.
24a. REC'D BY REGISTRAR DATE: MAY 22 61
24b REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5064

Reg. Dist No. 05954

1 PLACE OF DEATH
a COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 4 Weeks
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eckhart
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First HARRY Middle BENJAMIN Last SITES

4. DATE OF DEATH: Month 5 Day 29 Year 19 61

5. SEX: M
6 COLOR OR RACE: W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 9-5-1889
9 AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Kelly Worker
10b KIND OF BUSINESS OR INDUSTRY: Kelly Springfield Tire Co.
11. BIRTHPLACE (State or foreign country): Shaw, W.Va.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Frank Sites
14 MOTHER'S MAIDEN NAME: Betty Arnold

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No None
16 SOCIAL SECURITY NO: 214-07-1011
INFORMANT Address: Mrs. Harry Sites, Eckhart, Md.

(I)

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): arteriosclerosis & Nephritis — 3 years
DUE TO (c):

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. 490.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from 5/1/8, 1961, to 5/29, 1961, that I last saw the deceased alive on 5/29/61, 1961, and that death occurred at 6:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John B. Davis, M.D. — ADDRESS (Street, city or town, state): 7 Broadway — DATE SIGNED: 5/29/61

PHYSICIAN'S NAME (Type): John B. Davis, M.D. — Frostburg, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/31/61
22c NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery
22d LOCATION (City, town, or county) (State): Eckhart Md.

23 FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Hafer Funeral Home, 23 E. Main St. Frostburg, Md.
24a REC'D BY REGISTRAR DATE: JUN 2 '61
24b REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5065 **CERTIFICATE OF DEATH** 05955

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 285 E. MAIN STREET
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print) — First: MARY — Middle: W — Last: SLOAN
4. DATE OF DEATH — Month: 5 — Day: 24 — Year: 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 8-14-1880
9. AGE (In years last birthday): 81 — UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Alteration work
10b. KIND OF BUSINESS OR INDUSTRY: Department Store
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JAMES SLOAN
14. MOTHER'S MAIDEN NAME: MARGARET CARROLL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — None
16. SOCIAL SECURITY NO.: 214-05-8334
17. INFORMANT: XXXX James Sloan, c/o Gunter Hotel (Brother) — Address: E. Main St., Frostburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: instantly
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) [illegible]
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Senility
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT, WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town

21. I certify that (I) (this hospital) attended the deceased from 5/5, 19 61, to 5/24, 1961, that (I) (we) last saw the deceased alive on 5/23 19 61, and that death occured at 7 P.M, from the causes and on the date stated above
22a. SIGNATURE [signature] M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED [illegible]
22c. PHYSICIAN'S NAME (Type): S.G. WEISMAN
22d. ADDRESS: 59 GREENE STREET

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/27/61
23c. NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery
23d. LOCATION (City, town or county) (State): Frostburg Md.
24. FUNERAL DIRECTOR'S SIGNATURE [signature] — ADDRESS: Hafer Funeral Home Frostburg, Md.
25a. REC'D BY REGISTRAR DATE MAY 31 '61
25b. REGISTRAR'S SIGNATURE [signature]

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5066

CERTIFICATE OF DEATH

05056

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 59 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 127 Independence Street

d. STREET ADDRESS: 127 Independence Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Audrey Middle: Zenobia Last: Sluss

4. DATE OF DEATH: Month: May Day: 14 Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 4, 1902

9. AGE (In years last birthday): 59 yrs

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Matlick

14. MOTHER'S MAIDEN NAME: Almyra Wilhelm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: William C. Sluss Sr 127 Independence Street, Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 4 years

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Carcinoma of uterus

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 0 19 61, to May 14 1961, that (I) (we, last saw the deceased alive on May 14 1961, and that death occurred at 4 P.M. from the causes and on the date stated above

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ 22b. DATE SIGNED: May 16 61

22. PHYSICIAN'S NAME (Type): [signature] 22a. ADDRESS: Cumberland Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial 23b. DATE THEREOF: May 17, 1961 23c. NAME OF CEMETERY OR CREMATORY: Zion Memorial Park 23d. LOCATION (City, town, or county): Cumberland (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox ADDRESS: Cumberland Maryland

25a. REC'D BY REGISTRAR DATE: MAY 17 '61 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be used by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9 59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5067

CERTIFICATE OF DEATH

65057

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 1 Hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Route 1, Frostburg,
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul — Middle: Leo — Last: Smith

4. DATE OF DEATH: Month: May — Day: 7th, — Year: 19 61

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Aug. 11th, 1900
9 AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-Employer
10b KIND OF BUSINESS OR INDUSTRY: Grocery Store
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Lewis Smith
14 MOTHER'S MAIDEN NAME: Rose Ann Drumm

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 213-05-7128
17 INFORMANT: Mrs. Katherine L. Smith, Rt. 1, Frostburg, Md. — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 4 mo
DUE TO (b): Carcinoma Bladder — 2 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 1959 19 to May 7 1961, that (I) (we) last saw the deceased alive on May 5 1961, and that death occurred at 6:00 P.M., from the causes and on the date stated above.

22a SIGNATURE: W O McLane M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: May 9 1961
22c PHYSICIAN'S NAME (Type): W. O. McLane, M.D.
22d. ADDRESS: 167 E. Main Street, Frostburg, Md.

23a BURIAL REMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 5-10-61
23c NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery
23d LOCATION (City, town, or county) (State): Frostburg, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Durst
ADDRESS: Frostburg, Md.
25a RECD BY REGISTRAR DATE: MA
25b REG STRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 15M 9 59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5068 — 65058

1 PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL FLINTSTONE
c. LENGTH OF STAY IN 1b: 30 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ROUTE 1,

2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL FLINTSTONE
d. STREET ADDRESS: ROUTE 1,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DELLA — Middle: — Last: SOWERS

4. DATE OF DEATH: Month: MAY — Day: 28 — Year: 19 61

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG. 7, 1885

9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR / IF UNDER 24 HRS — Months: — Days: — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): KENNX MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FLOYD CROW

14. MOTHER'S MAIDEN NAME: MARGARET ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: ALVA SOWERS, ROUTE 1, FLINTSTONE, MD. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Stroke — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Paralysis attendant

DUE TO (c): Hypertension

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 26 19 61 to May 28 19 61 that (I) (we) last saw the deceased alive on May 28 19 61 and that death occurred at ___ M. from the causes and on the date stated above

22a. SIGNATURE: B. M. Schindler M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 5-29-61

22c. PHYSICIAN'S NAME (Type): B. M. SCHINDLER, M. D.

22d. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 31, 1961

23c. NAME OF CEMETERY OR CREMATORY: POCAHONTAS CEMETERY

23d. LOCATION (City, town or county) (State): POCAHONTAS, PA.

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: BYRON KIGHT CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE: [illegible]

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5068

Reg. Dist No. 45059

M

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1820 BEDFORD ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 1820 BEDFORD ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LEAH — Middle: W. — Last: SPOERL

4. DATE OF DEATH: Month: MAY — Day: 4 — Year: 19 1

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 7, 1912

9 AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: CHARLES C. WILLISON

14. MOTHER'S MAIDEN NAME: ALICE ROBINSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: FRANK SPOERL — Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION, LEFT — INTERVAL TWEEN ONSET AND DEATH: SUDDEN

4-2-61

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CORONARY OSTEAL SCLEROSIS — ----

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS A AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: May 4, 1961

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: MAY 6,1961

22c. NAME OF CEMETERY OR CREMATORY: HILLCREST BURIAL PARK

22d LOCATION (City, town, or county) (State): CUMBERLAND, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.

24a. REC'D BY REGISTRAR DATE: MAY 8 '61

24b. REGISTRAR'S SIGNATURE: C. Thos. L. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it. If same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5070 — Reg. Dist. No. 05060

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 35 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ROUTE 1 , VALLEY ROAD

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: ROUTE 1, VALLEY ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle VERNON — Last STEELE
4. DATE OF DEATH: Month MAY — Day 11 — Year 19 61

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 30, 1894
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER
10b. KIND OF BUSINESS OR INDUSTRY: HOUSE PAINTING
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: CHARLES STEELE
14. MOTHER'S MAIDEN NAME: LAURA WOODS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214058389
17. INFORMANT — Address: MARY STEELE, ROUTE 1, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO (b): CORONARY SCLEROSIS — ---
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: Benedict Skitarelic M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D. — May 11, 1961

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b DATE THEREOF: MAY 14,1961
22c. NAME OF CEMETERY OR CREMATORY: HILLCREST BURIAL PARK
22d. LOCATION (City, town, or county) (State): CUMBERLAND, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.
24a. REC'D BY REGISTRAR DATE: MAY 15 '61
24b. REGISTRAR'S SIGNATURE: Clinton S. Price.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5071 — 65061

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
1SM 9/59

1 PLACE OF DEATH a COUNTY: Allegany — MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE: Maryland — b COUNTY: Allegany
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland — c LENGTH OF STAY IN 1b: 8 Years	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 131 Independence Street	d STREET ADDRESS: 131 Independence Street — e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Mary		Swan		May	30	19 61

5 SEX	6 COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min
Female	White		May 12, 1878	83 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housekeeper	At Home	Maryland	U. S. A.

13 FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas McBride	Rachel McMasters

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17 INFORMANT	Address
No		Mrs. S. Leroy Durst	131 Independence Street, Cumberland, Maryland

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I — DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral [illegible]

DUE TO (b): [illegible]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour, a.m. p.m., Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from [illegible] 19[illegible] to [illegible] 19[illegible] that (I) (we) last saw the deceased alive on [illegible] 19[illegible] and that death occurred at [illegible] M. from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒ MEDICAL DIRECTOR ☐ STAFF PHYS. ☐	22b DATE SIGNED
[illegible]			

22c PHYSICIAN'S NAME (Type)	22d ADDRESS
	[illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City, town, or county, State)
Burial	June 2, 1961	Hillcrest Burial Park	Cumberland Maryland

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
H. Lee Silcox	Cumberland Maryland	JUN 5 '61	[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5072

CERTIFICATE OF DEATH

05062

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 10 HOURS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL — WARWICK & MEMORIAL AVENUES

2. USUAL RESIDENCE (Where deceased lived. If institution, last residence before admission.)
a. STATE: WEST VIRGINIA
b. COUNTY: MINERAL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PAW PAW
d. STREET ADDRESS: [illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: IRA — Middle: A. — Last: THOMAS

4. DATE OF DEATH: Month: MAY — Day: 10 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEBRUARY 4, 1885

9. AGE (In years last birthday) 76 yrs. — IF UNDER 1 YEAR (Months / Days) — IF UNDER 24 HRS. (Hours / Min)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Retailer

10b. KIND OF BUSINESS OR INDUSTRY: Gen. Mdse

11. BIRTHPLACE (City & State or foreign country): NEBRASKA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ANDREW THOMAS

14. MOTHER'S MAIDEN NAME: MARTHA WYMORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 720-18-3284

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO
b: Arterio Sclerosis Cerebral
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: Approx. 1 day

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Chronic A.C.D.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. City or town

21. I certify that (I) (this hospital) attended the deceased from April, 1960 to May 10, 1961, that (I) (we) last saw the deceased alive on May 10 1961 and that death occured at 12:40PM from the causes and on the date stated above

22a. SIGNATURE: John A. Topper M.D.

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-11-61

22c. PHYSICIAN'S NAME (Type): DR. JOHN A. TOPPER

22d. ADDRESS: HYNDMAN, PA.

23a. BURIAL CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/13/61

23c. NAME OF CEMETERY OR CREMATORY: Levels, W. Va.

23d. LOCATION (City, town or county) (State): Levels, Hampshire, W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: PARKS-JOHNSON

ADDRESS: BERKELEY SPRINGS, W. VA.

25a. REC'D BY REGISTRAR: MAY 15 '61

25b. REG STRAR'S SIGNATURE: Clifton E. Knode

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5073 — 05063

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN MARYLAND: 2 HRS. 25 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Resident ... before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 1 S. WAVERLY TERRACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle Sloan Last THOMAS

4. DATE OF DEATH: Month MAY Day 13, Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 2, 1889

9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months ... Days ... IF UNDER 2 DAYS: Hours ... Min ...

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED Foreman

10b. KIND OF BUSINESS OR INDUSTRY: B & O RR

11. BIRTHPLACE (City & State or foreign country): KANSAS, Opeto

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ANDREW THOMAS

14. MOTHER'S MAIDEN NAME: ALICE WYMORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Address: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b and c.)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE a: Coronary Thrombosis & Infarction. 3 hrs

DUE TO (b): Coronary Sclerosis 7 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June ..., 19 5 4 to May 13, 1961, that (I) (we) last saw the deceased alive on May 13 1961, and that death occured at 2:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/13/61

22c. PHYSICIAN'S NAME (Type): DR. CLAY DURRETT

22d. ADDRESS: 236 VIRGINIA AVENUE, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/16/61

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Catholic Cem.

23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John J. Hafer, Cumberland, Maryland

25a. RECD BY REGISTRAR: MAY 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur J. Krause

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 Lewis Brings

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5074 Reg. Dist. No. 05064

(M)

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN Tb: 75Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 308 Central Ave.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 308 Central Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ X

3. NAME OF DECEASED (Type or print): First JOHN Middle HENRY Last TROST

4. DATE OF DEATH: Month May Day 4, Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 19, 1880
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Furniture
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Samuel H. Trost
14. MOTHER'S MAIDEN NAME: Anna Geldhaus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: Miss. Mildred Trost Address: Cumberland, Md.

(I)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized arteriosclerosis — 1 year
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-3, 1961 to 5-4, 1961, that I last saw the deceased alive on 5-2, 1961, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lewis Brings M.D. ADDRESS (Street, city or town, state): 57 Greene St. Cumberland, Md. DATE SIGNED: 5-5-61

PHYSICIAN'S NAME (Type): LEWIS BRINGS

22a. BURIAL CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 6, 1961
22c. NAME OF CEMETERY OR CREMATORY: S.S. Peter & Paul
22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Charles L. George Cumberland, Md.
24a. REC'D BY REGISTRAR DATE: MAY 8 '61
24b. REGISTRAR'S SIGNATURE: Clarence O. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5975

Reg. Dist. No. 15065

1. PLACE OF DEATH
a COUNTY: Allegany — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. # 3 Cumberland,
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Bedford Road

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland — b COUNTY: Allegany
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. # 3 Cumberland,
d STREET ADDRESS: Bedford Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First IDA — Middle BELLE — Last VALENTINE
4 DATE OF DEATH: Month May — Day 26, — Year 1961

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Dec. 22, 1900
9 AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Own home
11 BIRTHPLACE (State or foreign country): Chaneysville, Penna.
12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13 FATHER'S NAME: James Bridges
14. MOTHER'S MAIDEN NAME: Agnes Bartholow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No, (If yes, give war or dates of service)
16 SOCIAL SECURITY NO: None
17. INFORMANT Address: Mr. Carl Valentine Rt. # 3 Cumberland, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebral arteriosclerosis + Hypertension
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from January, 19 61, to May 26, 19 61, that I last saw the deceased alive on May 24, 19 61, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William P. James M.D
ADDRESS (Street, city or town, state): 441 N. Centre St., Cumberland, Md.
DATE SIGNED
PHYSICIAN'S NAME (Type): William P. James M.D.

22a BURIAL CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 5/29/61
22c NAME OF CEMETERY OR CREMATORY: Zion Memorial Cemetery
22d LOCATION (City, town, or county) (State): Cumberland, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Charles L. George
ADDRESS: Cumberland, Md.
24a REC'D BY REGISTRAR DATE: MAY 31 1961
24b REGISTRAR'S SIGNATURE: Carl P. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5076

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05066

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 35 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 506 PARK ST.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: XXXX 506 PARK ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEIMAN Middle ABEL Last VEACH

4. DATE OF DEATH: Month MAY Day 2 Year 19 61

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JUNE 9,1903
9. AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): REPAIRMAN
10b. KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED
11. BIRTHPLACE (State or foreign country): W. VA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN A. VEACH
14. MOTHER'S MAIDEN NAME: KATHRYN JACK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service: NO
16. SOCIAL SECURITY NO: NONE
17. INFORMANT: MRS. JOHN VEACH Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ASPHYXIATION — INTERVAL BETWEEN ONSET AND DEATH: 3-5 Min.

1 X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) PLASTIC BAG OVERX HEAD — 3-5 Min.

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: May 26, 1961

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MAY 29,1961
22c. NAME OF CEMETERY OR CREMATORY: HIGH CEMETERY
22d. LOCATION (City, town, or county) (State): XXXXX PURGITSVILLE, W. VA.

23. FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT ADDRESS: CUMBERLAND, MD.
24a. REC'D BY REGISTRAR DATE JUN [illegible] 61
24b. REGISTRAR'S SIGNATURE

TO DE[illegible] MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5077

CERTIFICATE OF DEATH

U5067

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MARYLAND
c. LENGTH OF STAY IN this place: 7 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits write RURAL): OLDTOWN RT. #1
d. STREET ADDRESS: Oldtown Rt# I
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First GEORGE Middle W. Last WAGNER

4. DATE OF DEATH: Month MAY Day 24, Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 2-22-1889

9. AGE (In years last birthday): 72 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Labor

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (City or town & State or foreign country): Greenspring WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM WAGNER

14. MOTHER'S MAIDEN NAME: ETTA WARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-14-6751

17. INFORMANT (Address): MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Coronary Occlusion

DUE TO (b): Hypertension Arteriosclerosis Acute Ventricular Heart Failure

DUE TO (c): Nephritis.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Hours / Years / Weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. / p.m. Month Day Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) / City or town / County / State

21. I certify that (I) (this hospital) attended the deceased from June 6, 1957 to May, 1961, that (I) (we) last saw the deceased alive on May 24 1961, and that death occured at 6:32 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature]

22b. DATE SIGNED: 5/2/61

22c. PHYSICIAN'S NAME (Type): DR. G.O. HIMMELWRIGHT

M.D. ATTENDING PHY. [X] MED. DIRECTOR [ ] STAFF PHYS [ ]

22d. ADDRESS: 133 VIRGINIA AVE., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-27-61

23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem.

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: James F. Scarpelli Cumberland, Md.

25a. REC'D BY REGISTRAR: DATE MAY 31 '61

25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5078 — 65068

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Robbins Street

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Robbins Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: MARGARET — Middle: — Last: WILAND

4 DATE OF DEATH: Month: May — Day: 5th. — Year: 1961

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Aug, 30th, 1898

9 AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Barton, MD.

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Michael Leyden

14. MOTHER'S MAIDEN NAME: Margaret Lashbaugh

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16 SOCIAL SECURITY NO: None

17 INFORMANT: John Wiland (SON) — Address: Lonaconing, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
DUE TO (b): Arteriosclerosis — 4 yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Hypothyroidism

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT, WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Month, Day, Year — Hour: a.m. / p.m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Aug. 1956 to May 5 1961 that (I) (we) last saw the deceased alive on Apr. 7 1961, and that death occurred at 1 P.M., from the causes and on the date stated above

22a SIGNATURE: [signature] M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 5/6/61

22c PHYSICIAN'S NAME (Type): L R MILES JR, M.D

22d ADDRESS: Lonaconing

23a BURIAL CREMATION REMOVAL (Specify): Burial — 23b DATE THEREOF: 5/8/1961

23c NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

23d LOCATION (City, town or county, State): Lonaconing, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN — ADDRESS: LONACONING, MD.

25a REC'D BY REGISTRAR DATE: —

25b REGISTRAR'S SIGNATURE: —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9-59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5079 — 65069

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 10 Days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Miners Hospital

2. USUAL RESIDENCE (Where deceased lived first listed on Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): R-F-D. #1 Frostburg, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle Last WILSON

4. DATE OF DEATH: Month 5/29/1961 Day Year 19

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/31/1876
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nohe
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Lonaconing, MD.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Workman
14. MOTHER'S MAIDEN NAME: Rebecca Schriff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs. Arthur Lemmert (Cousin) Address: Mt. Savage, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.
DUE TO (b): Arteriosclerotic Cardio-vascular disease — years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. / p.m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-18 1961, to 5-29, 1961 that (I) (we) last saw the deceased alive on 5-29-1961, and that death occurred at 5 P.M. from the causes and on the date stated above

22a. SIGNATURE: L. R. Miles JR. M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6-1-61
22c. PHYSICIAN'S NAME (Type): L.R. MILES JR., M.D.
22d. ADDRESS: Lonaconing, Md.

23. BURIAL CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/1/1961
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park
23d. LOCATION (City, town, or county) (State): Frostburg, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN
ADDRESS: LONACONING, MD.
25a. REC'D BY REGISTRAR DATE: JUN 5 '61
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN. This law requires that the death certificate be executed with in 24 hours after death. Page 4 may be filled by the hospital or attending physician
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5080

CERTIFICATE OF DEATH

65070

1 PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 1 HOUR
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.

2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
d. STREET ADDRESS: 308 MT. VIEW DRIVE
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3 NAME OF DECEASED (Type or print): First: ORION Middle: OLIVER Last: WILSON

4 DATE OF DEATH: Month: MAY Day: 14 Year: 1961

5 SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: APRIL 4, 1878

9 AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hardware Store

10b. KIND OF BUSINESS OR INDUSTRY: Self.

11 BIRTHPLACE (City & State or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: OLIVER WILSON

14. MOTHER'S MAIDEN NAME: Emma FISHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-32-3422

17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

DUE TO (b): Coronary arteriosclerosis — ?

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Duodenal ulcer; myocardial fibrosis; left ventricular hypertrophy

19 WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a ACCIDENT WAS INDEPENDENT OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

2Dd. INJURY OCCURRED While at work [ ] Not While at work [ ]

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. City or town, (County), State.

21. **I certify** that (I) (this hospital) attended the deceased from June 19 59 to May 14, 19 61, that (I) (we) last saw the deceased alive on May 14, 19 61, and that death occured at 4:45PM from the causes and on the date stated above.

22a SIGNATURE: Samuel Jacobson M.D.

ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]

22b DATE SIGNED: 5/15/61

22c PHYSICIAN'S NAME (Type): DR. SAMUEL JACOBSON

22d ADDRESS: 50 Pershing St. Cumberland, Md.

23a. BURIAL CREMATION, REMOVAL (Specify): intombment

23b DATE THEREOF: May 17, 1961

23c NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county, State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Towers Stein Inc. ADDRESS: 117 Frederick St. Cumb. Md.

25e. REC'D BY REGISTRAR DATE: MAY 18 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5081 — 65071

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eckhart
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Eckhart
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Jane — Last: Wright

4. DATE OF DEATH: Month: May — Day: 8th, — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 28th, 1879

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Pape

14. MOTHER'S MAIDEN NAME: Eliza Susan Coppage

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. Upton Loar, Eckhart, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 mo
DUE TO (b): Arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Apr 1 1961 to May 8 1961, that (I) (we) last saw the deceased alive on May 7 1961, and that death occurred at 2:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Wm McLane M.D.

ATTENDING PHYS. X MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: May 9 1961

22c. PHYSICIAN'S NAME (Type): W. O. McLane, "

22d. ADDRESS: 167 E. Main St., Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-11-61

23c. NAME OF CEMETERY OR CREMATORY: Porter Cemetery

23d. LOCATION (City, town, or county) (State): Eckhart, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Joseph R Durst & Son Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: MAY 10 '61

25b. REGISTRAR'S SIGNATURE: Clothus L. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5082 65072

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: IO/II/56
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 325 Holland Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Alvey — Middle Gerald — Last Zembower

4. DATE OF DEATH: Month May — Day IO — Year 19 6I

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/9/79
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Bookkeeper
10b. KIND OF BUSINESS OR INDUSTRY: Clothing Store
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Adam W. Zembower
14. MOTHER'S MAIDEN NAME: Mary J. Rose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: P.O.Box. 599 Address Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary Hypostasis	24 hrs.
DUE TO (b)	Chronic Myocarditis	?
DUE TO (c)	Cerebral arteriosclerosis	?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Hemorrhage

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from IO/II/56, 19___, to 5/IO/6I, 19___, that (I) (we) last saw the deceased alive on 5/9/6I, 19___, and that death occurred at 7:00 A. M. P. M. from the causes and on the date stated above

22a. SIGNATURE: James E. McLean M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS ☒
22b. DATE SIGNED: 5/9/XXXX 5/IO/6I
22c. PHYSICIAN'S NAME (Type): Dr. James E. McLean
22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 12, 1961
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county): Cumberland (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Fous Stein, Inc. ADDRESS: Cumberland, Md.
25a. RECD BY REGISTRAR DATE: MAY 15 '61
25b. REGISTRAR'S SIGNATURE: Clifton L. Friend

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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